

Department of Social Research
University of Helsinki
Helsinki

INSTITUTIONAL FOOTPRINTS IN THE ADDICTION IMAGE:

A FOCUS-GROUP STUDY WITH FINNISH AND FRENCH
GENERAL PRACTITIONERS AND SOCIAL WORKERS

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ACADEMIC DISSERTATION

To be presented, with the permission of the Faculty of Social Sciences of the University of Helsinki, for public examination in lecture room P674, Porthania building (Yliopistonkatu 3), on September 12, 2014, at 12 noon.

Helsinki 2014

Publications of the Department of Social Research 2014:16
Sociology

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Cover: Jere Kasanen
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Distribution and Sales:
Unigrafia Bookstore
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PL 4 (Vuorikatu 3 A) 00014 Helsingin yliopisto

ISSN-L 1798-9140
ISSN 1798-9132 (Online)
ISSN 1798-9140 (Print)
ISBN 978-952-10- 9121-6 (paperback)
ISBN 978-952-10- 9122-3 (PDF)

Unigrafia, Helsinki 2014

ABSTRACT

The concept of addiction is increasingly applied in order to understand various problematic behaviours. However, this inclusion remains disputed.

The study examines the conceptualisation of addictions by analysing stimulated group discussions of general practitioners and social workers in Finland and France on the topics of alcoholism, pathological gambling and eating disorders. The dissertation consists of one methodological working-paper (I.), three empirical sub-studies (II., III., and IV.) and a summary article. Sub-study III. was written together with Matilda Hellman and Pekka Sulkunen.

The study builds on the assumption that social reality is constructed and taken-for-granted. Concepts develop in a certain cultural context. Culture in its different occurrences is the framework for thinking and acting. This study is particularly concerned with institutions as one occurrence of culture.

The empirical bases of the enquiry are 27 Reception Analytical Group Interviews, which challenged the participants to question their taken-for-granted understanding of addiction by presenting them with short film clips.

Finnish informants focus on the harm done towards the family and society and therefore follow the traditional Finnish non-medical model. French participants by contrast laid emphasis on the suffering of the individual addict and consequently express characteristics of the medical model (II., III., and IV.). Secondly, Finnish social workers understand all three problem behaviours similarly as social problems, whereas their French colleagues understand alcohol and eating problems as individual issues. A common denominator in both countries is a functional explanation of all three problem behaviours as a form of poor coping with life's hardships (except for gambling in France) (III. and IV.). Finally the study shows that in the context of the modern Finnish welfare state the importance of citizens' autonomy allows individual excess to some extent, as long as innocent others are not harmed (III.).

This study traced the influence of institutions on images of addiction. It suggests considering addiction as culture-level bound. Beside the traditional concept of addiction other institutional settings also have an impact on the images of addiction. Due to the complexity of the contexts involved, this dissertation recommends cautiousness when including behavioural excesses under the umbrella of addiction. Treatment research should take into account institutionally embedded understandings of addictions when implementing new treatment strategies and policy approaches from other cultural contexts. This dissertation asks for a layered concept of culture, which can account for the multifarious influences of the social context on the concept of addiction.

ACKNOWLEDGEMENTS

Writing this dissertation was a long lasting endeavour and during this time I too often took the support I received for granted. I want to take the convention of the acknowledgements as an opportunity to reflect on all the help I got during the last years and to thank for it.

First of all I want to thank my supervisor Pekka Sulkunen. He was the one who awoke my interest in addiction studies in the first place. He also invited me to come back to Finland to write my dissertation. With his incredible large amount of knowledge in addiction research and inspirational insights into Sociology and beyond he always brought me back on track, when I was lost in my data, the analysis or in writing a concise article. Not least, he as well took care and helped organising the financial backup necessary for the research, conference participations and my living.

I want to thank my pre-examiners Kati Rantala and Jessica Storbjörk for their valuable comments to improve the dissertation manuscript and for their fast work – without their effort I would not be writing these lines already today.

I started this dissertation in the IMAGES project and had the pleasure there to collaborate with researchers from Finland and abroad. Especially I want to thank Aino Manninen for her help with the interviews in Finland, as well as, Laurence Simmat-Durand and Chantal Mougin from the Cermes 3 (Université Paris Descartes) for collecting the data in France and sharing their thoughtful insights into the French way of dealing with addiction.

The PhD seminar “Interventio” and the Centre for Research on Addiction, Control and Governance CEACG-meetings were of indispensable help for my work. It was a blessing to have such supportive research environments and I want to thank Anna Alanko, Matilda Hellman, Kaisa Hintikka, Matias Karekallas, Anu Katainen, Tuula Kekki, Johanna Korkeamäki, Anja Koski-Jännes, Riikka Kotanen, Petra Kouvonen, Anna Leppo, Maija Majamäki, Anne Mattila, Janne Nikkinen, Yaira Obstbaum, Riikka Perälä, Otto Pipatti, Virve Pöysti, Varpu Rantala, Helka Raivio, Sanna Rönkä, Arto Ruuska, Pauliina Seppälä, Jenni Simonen, Mirka Smolej, Sari Vesikansa, and many more for their fruitful comments and intelligent remarks on my manuscripts and research plans.

I am grateful to the European Graduate School in Addiction Research (Technical University Dresden) ESADD, which opened for me the window into psychological and biological perspectives on addiction. I appreciated the friendly atmosphere and want to thank the organisers, Gerhard Bühringer, Silke Behrendt, Sarah Forberger, and Katharina Nitzsche, as well as my fellow students Julia Becker, Regina Hinterreiter, Lisa Jakob, Máté Kapitány-Fövény, Francisco Orosa, Thomas Pronk, Diana Sakae, Lidia

Segura Garcia, Johannes Thrul, Regina van der Meer, Nickie van der Wulp, Claire Wilkinson, and Eva-Maria Zenses.

I thank the members of the Department of Social Research (University of Helsinki) for welcoming me in their midst and the University for providing me the space and infrastructure to work. This study would not have been possible without the funding from the Academy of Finland, the Finnish Ministry of Social Affairs and Health, the Finnish Doctoral Program in Social Sciences (SOVAKO) and the Finnish Foundation for Alcohol Studies.

The last years would have been unbearable without my friends here and across the Baltic Sea. With them I could leave the dark realm of alcohol, gambling and eating problems for a while and set my mind to the more pleasurable sides of life. For this help in keeping myself mentally, but also physically in shape I would like to thank especially Sven Dress, Mathias Jäger, and Karol Schober.

I would like to thank my brother, Johannes Egerer, my sister Sabine Zufall and her family, and my parents, Gerhard and Rotraud Egerer for being always there when I need them.

Finally, I want to thank my partner Johanna Vuorinen, for bearing my occasional moods while working on the dissertation with unbelievable patience and for knowing when and how to cheer me up again.

Helsinki, in the summer of 2014

Michael Egerer

CONTENTS

Abstract	3
Acknowledgements	4
Contents	6
List of original publications.....	8
Abbreviations.....	9
1 Introduction.....	11
a. Lay and specialist images of addiction	14
b. Research aim, questions and contribution	15
2 Concepts of addiction.....	17
a. Overview: neurobiology, psychology and rational choice.....	17
b. Syndrome theory	18
c. Disease models	19
d. A pathology of modernity	20
e. Addiction – a working perspective	21
3 Theoretical design	23
4 Comparing Finland and France	28
a. The Finnish and French institutional context of handling addiction	28
b. Gambling and eating disorder(s)	30
5 Method and data	33
a. The Reception Analytical Group Interview RAGI	33
b. Data	38
c. Analysis of interview discussions.....	39
6 Results.....	42

a.	Role of profession in treating problem drinking, gambling and eating	42
b.	Harm caused by problem drinking, gambling and eating.....	45
c.	Responsibility for recovery	47
d.	The root and explanation of problem drinking, gambling and eating	48
7	Conclusions	51
	References	56

LIST OF ORIGINAL PUBLICATIONS

This thesis is based on the following publications:

- I Egerer, M. (2010): *Gate keepers' images of addiction in Finland, France, and Germany. The film-clips in the group interviews*. Helsinki: University of Helsinki, Department of Social Research.¹
- II Egerer, M. (2012): Alcoholism, brief intervention and the institutional context: a focus-group study with French and Finnish general practitioners. *Critical Public Health*. Volume 22, Number 3, 1 September 2012: 307-318.
- III Egerer, M., Hellman, M. & Sulkunen, P. (2012): Autonomy and protection in the welfare state: Finnish social workers' views on alcohol problems. In M. Hellman, G. Roos, & J. von Wright (Eds.) *A Welfare Policy Patchwork. Negotiating the public good in times of transition* (pp. 203-222). Helsinki: Nordens välfärdscenter.
- IV Egerer, M. (2013): Problem drinking, gambling and eating – three problems, one understanding? A qualitative comparison between French and Finnish social workers. *Nordic Studies on Alcohol and Drugs*. Vol. 30, 2013, 1-2: 67-86.

The publications are referred to in the text by their roman numerals.

¹ The Interview protocol with the stimulus film-clips was developed for interviews in Finland, France and Germany. The analysis of the German data is, however, not part of this dissertation.

ABBREVIATIONS

AA	Alcoholics Anonymous
APA	American Psychiatric Association
AUDIT	Alcohol Use Disorders Identification Test
BED	Binge Eating Disorder
CCAA	Centres de consultation ambulatoire en alcoologie
C.H.A.	Centre d'Hygiène Alimentaire
C.H.A.A.	Centre d'Hygiène Alimentaire et d'Alcoologie
DSM	Diagnostic and Statistical Manual of Mental Disorders
e.g.	exempli gratia
etc.	et cetera
ibid.	ibidem
ICD	International Classification of Diseases
i.e.	id est
GP	general practitioner
RAGI	Reception Analytical Group Interview
SOGS	South Oaks Gambling Screen
SW	social worker
WHO	World Health Organisation

1 INTRODUCTION

In recent years the concept of addiction has increasingly been applied to understanding various problematic behaviours. Gambling-related problems and eating disorders are discussed in terms of addiction (e.g. Jacobs et al. 1985, Orford 2001, Elster 2003) and diagnostic criteria originally developed for substance-based dependencies (WHO 1992, APA 2000) – loss of control, tolerance, withdrawal, continuation despite harms – are used to define gambling and excessive eating. Gambling disorder is now included in the new fifth Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in the “Substance-Related and Addictive Disorders” category (APA 2013a). Despite these developments, the inclusion of behavioural problems in the concept of addiction and addiction as a unitary concept remains highly disputed and the concept of addiction itself is far from being a clear-cut unity (Reinarman 2005, Edman 2009).

Among lay populations and addiction specialists there are numerous ways of understanding excessive self-harming behaviours, i.e. addictions. The disease concept of addiction is a common approach to make sense of excessive and harmful consumptions and behaviours, namely that consumption or behaviour is not under control because of a (genetic) predisposition of the individual. AA’s disease model even claims that only abstinence is the way to prevent the harms caused by the substance or by behaviour, though healing of the addiction remains impossible. In current scientific terminology shared by influential circles of addiction researchers, addiction is a chronic relapsing brain disease (e.g. Kalivas & Volkow 2005). On the grounds of neurobiological similarities with substance dependence, inhibited eating has also come to be classified as a brain disorder (Volkow & O’Brien 2007, Johnson & Kenny 2010).

However, in identification and treatment a syndrome theory of addiction is prominent. This classifies behaviours as addictions of different severity, depending on how many indicators in diagnostic manuals and screening instruments (e.g. Alcohol Use Disorders Identification Test AUDIT, South Oaks Gambling Screen SOGS, International Classification of Diseases ICD-10, or DSM-5) are met. An alternative understanding, not based on the individual, namely the public health approach (e.g. Edwards et al. 1994), puts its emphasis on the exposure to alcohol, drugs, or unhealthy food on the population level.

An addition to the aforementioned “realist” perspectives on addiction is a constructivist understanding of addiction, which places the problem of harmful excessive consumptions or behaviours into a cultural context: addiction is not a phenomenon itself, but a way to conceptualise a problem in the terms and under the perspective of a certain time and space. Harry Levine (1978) has shown how alcoholism appears in the context of the

protestant and rationalised period of (American) industrialisation, filling the need to make sense of excessive and irrational drinking. Before this time, Levine (1978) points out, the same kind of problem has not been understood as a loss of control, nor a medical issue, but as a sin and as gluttony.

Looking at all these different approaches, it becomes obvious how controversial the concept of addiction still is and that there is no one coherent view (Edman 2009). According to Pekka Sulkunen (2007), this confusion results from a misunderstood division between culture and nature: Nature is conceived as something outside of human influence and different from culture, being seen as a man-made phenomenon which exceeds nature. In the addiction field this split re-appears in the scientific disciplines. Whereas neurobiologists claim that addiction is a given phenomenon of nature, taking social factors only as predictors and as being extrinsic to the brain disease (Room 1978), sociologists tend to define addiction as a societal construct, often neglecting the biochemical effects of, for example, alcohol (e.g. Demant 2009).

Jon Elster (1999) takes emotions as a point in case to develop a more comprehensive understanding of how biology is seated in the social: Except for a few "immediate" feelings, like vertigo, emotions like affection, grief and love are culturally shaped, and while growing up, children learn how to experience and interpret such feelings. In a similar way the novice marijuana user, for example, has first to learn how to experience the pharmacological effects of marijuana in the body (Becker 1953). I agree with Becker (1953) and Elster (1999) and consequently recognise that addictions are also biologically – happening in the body – as well as socially framed, i.e. the experience of addiction itself is learned (Reinarman 2005). Addictions are culture-bound and differ in time and space (Room 1985). Davies supports this approach by claiming that "the meaning, experience and implications" of drug use are dependent on the "major structural components of the legal, medical and social systems" (Davies 1997: p. 161).

But what roles do the meaning of e.g. alcohol consumption and of experiences such as gambling play in the understanding of addiction? The way we understand the world and act within it is fundamentally structured by images (Boulding 1956, Sulkunen accepted): images are the subjective knowledge we have accumulated about the world in which we live. New information and experiences are filtered through already existing images. Images or social representations order and classify the world (Moscovici 1984). Although images are the subjective knowledge of the world, it is shared inter-subjectively and we also have an image of the images of the other. Berger and Luckmann (1967) explain how the inter-subjective view of the world – our social reality – is constructed. In thought collectives congruent images appear and are constantly exchanged and re-interpreted (Douglas 1986). Thought collectives are more commonly referred to as culture. Culture is a self-produced web of meaning and includes a notion of a natural order of things (Lévi-Strauss 1968, Geertz 2011). But also on the

meso-level thought styles exist and, for example, occupation subcultures like the medical profession have their public image of the world. Following this approach, images are tested group experiences, which not only are scripts and schemes for acting, but also span the future horizon of experience and are the filter through which we process new information (Boulding 1956, Schütz & Luckmann 2003). Scripts, schemes and concepts to understand the world eventually become solidified in institutions and hence become independent of the particular group of individuals who share these images. However, there are not only objectified cognitive acts and their images, there are also repeated bodily and non-conscious behaviours which result in dispositions to act, also known as habits (Gronow 2011). Institutions are therefore not only regulative (based on long-lasting rules), normative (based on binding norms) and cognitive and, therefore serving as taken-for-granted scripts for perceiving the world and acting in it (Scott, 1995), they are also "habitual" (Gronow 2011). Such habitual "*institutions are established and prevalent social dispositions that structure social (inter)action*" (Gronow 2011: p. 99 [italics in original]). These established dispositions of behaviour often relieve us from even the most awkward and important decisions (Douglas 1986). Institutions are maintained by the interaction between the members of the thought collective and by the application of images to experiences and the discussion about previous conversation (Klatetzki 2006).

In this dissertation I study Finnish and French general practitioners' and social workers' conversation about problem drinking, gambling and eating in order to evaluate the suitability of a unitary concept of addiction. I do so by specifically investigating the influence of the country-specific institutional arrangement of handling addictions. This arrangement has to be understood as one of many different occurrences of culture, besides for example, more permanent cultural dispositions such as collectivistic and individualistic value traits inside a population (Sulkunen 2013). I decided to apply not only a qualitative approach – in order to identify the underlying discursive structures in interviewees' discussions – but also a group interview setting. Such a setting facilitates a discourse about the research subject between the informants from the same institutional context, instead of between informant and interviewer, as in a single interview. The Reception Analytical Group Interview RAGI used in this study (Sulkunen & Egerer 2009) encourages the application of participants' images onto the addiction experiences presented by stimulus film clips, in the context of the occupational subcultures of general practitioners and social workers in Finland and France. The short vignettes bring incidences that have happened somewhere else and at another time into the interview situation (Törrönen 2002) and portray problems associated with alcohol dependence, pathological gambling and eating disorders (working-paper I.). I am using a comparative approach in order to evaluate the impact of the institutional context on participants' images of the three disorders and their attitudes concerning the problems shown (Kjaernes et al. 2007). Attitudes are initially

often understood as permanent personality traits disconnected from the cultural and institutional context. However, I understand them to be fundamentally embedded in the social environment, being the individual response dispositions based on the collective images of the population (Jaspers & Fraser 1984).

a. Lay and specialist images of addiction

Previous research on the collective images of populations on addictions has shown that the Finnish population perceives alcohol to be the biggest threat for their society (Hirschovits-Gerz and Koski-Jännes 2010). For the individual, however, participants in the same survey consider other substances, such as cannabis and amphetamines, to be more problematic. Also the assignment of responsibility for causing the problem and its resolution differs between the different addictions (Blomqvist 2009, Koski-Jännes et al. 2012, Hirschovits-Gerz 2013). Hirschovits-Gerz and colleagues (2011) have demonstrated that the Finnish population in comparison to other people place special emphasis on the responsibility of individuals to break free from addiction. The importance of personal self-control and competitive struggle in Finland was also identified by Pöysti and Majamäki (2013) and Majamäki and Pöysti (2012), who compared Finnish and French recreational gamblers. However, not only in comparisons between countries could different collective images be recognised, differences could also be noticed between professional groups. Pennonen and Koski-Jännes (2010), for example, detected differences in the ascription of responsibility between different professions inside the Finnish treatment system, where staff with a social work background are more likely to hold what Philip Brickman and colleagues (1982) call a "compensatory model" (responsible for recovery, but not for the dependency), whereas nurses and doctors rely on the "moral model" (Brickman et al. *ibid.*) and therefore consider the addict to be responsible for the dependency and its recovery.

Outside specialised treatment general practitioners (GPs) and ordinary social workers (SWs) hold the "gate keeping" position in handling addictions, as they are the first "officials" who come into contact with the problem and have to decide on the necessity for and the kind of further measures (e.g. Rush et al. 1994, Bliss & Pecukonis 2009). These professions have been the topic of many addiction studies (e.g. Manohar et al. 1976, Richmond & Anderson 1994, Rush et al. 1994, Deehan et al. 1998, Kaner et al. 1999, McAvoy et al. 1999, Ashenberg Straussner 2001, Aalto et al. 2003, Bliss & Pecukonis 2009). However, most earlier studies lack a cross-cultural angle by taking the institutional and cultural context of these professions for granted. This study instead looks at institutions as one occurrence of the cultural context (Sulkunen 2013). It approaches GPs and SWs as "experienced laypersons" when it comes to addiction: they have frequent contact with addiction problems in their daily work, but lack special

education and tools on how to deal with this matter. Hence, they have only a little “specialised addiction knowledge” to rely on and have instead to filter their work experiences with addiction like laypersons by referring to images obtained from everyday media (see e.g. Christensen et al. 2001) and by referring to dispositions given by their institutional context, and therefore to the historically grown country-specific position of GPs and SWs in the addiction field.

GPs in Finland are only peripherally involved in the treatment of addiction, whereas the medical profession in France has a strong role in the treatment of addictions (Takala & Lehto 1992, Mossé 1992, Bergeron 2001). SWs, on the other side, have only an auxiliary function in French outpatient treatment (Thiry-Bour 1996), whereas in Finland specialised social case workers are the leading profession in A-clinics (Ahonen 2007) – ordinary SWs, however, have not been assigned the task of treating addictions (Satka 1995). In Finland a “non-medical” model is the primary principle, where alcohol and drug problems are seen as a social problem (Bruun 1971), while the French medical model is concerned with alcohol problems as an individual medical problem (Berlivet 2007). Both countries show a transition from coercive in-patient, or in-prison handling of addiction problems towards the present outpatient approach (Mäkelä & Säilä 1986, Thiry-Bour 1996, Ahonen 2007, Berlivet 2007) and therefore exemplify the shift from external measures of control towards internal ways, i.e. placing the responsibility for recovery on the individual (Ferentzy 2002).

b. Research aim, questions and contribution

This dissertation evaluates the appropriateness of a unitary concept of addiction by investigating the cultural embeddedness of addiction, as well as by taking the country-specific system of dealing with addictions and primary health and social care institutions as important factors contributing towards understanding excessive and harmful substance consumption or behaviour. Sub-study II. concentrates on a comparison between Finnish and French GPs and their role perception in dealing with alcohol dependence and their images of problem drinking. Sub-study III. investigates the contradictory position of SWs in handling problem drinking in the Finnish welfare state. Finally, sub-study IV. compares Finnish and French social workers’ understanding of three different excessive appetites (excessive drinking, gambling and eating) in order to look into common denominators of addiction.

In particular, the sub-studies ask:

1. What kind of understanding do GPs have of alcohol dependence in Finland and in France? Is their role perception in handling drinking problems institutionally shaped?

2. Do Finnish SWs conceptualise problem drinking in a social frame, and where do they draw the line between heavy drinking and alcohol dependence?
3. Does the country-specific concept of addiction serve for Finnish as well as for French social workers as a model for making sense of problem gambling and eating?

This dissertation is different from many cultural studies on addiction in two ways. Firstly, it asks the gatekeepers of the modern welfare state (i.e. GPs and SWs) about their addiction images, instead of enquiring into “affected” (i.e. “addicts”), treatment specialist or lay persons’ images. As important as it is to know their perspectives, these studies tend to identify addicts’ justifications (Davies 1997) as to some degree replicating specialist treatment textbooks, or reflecting media images. Instead, this study brings to light a composite perspective on addictions: a multiple perspective which includes experiences with the problem, lay addiction knowledge, medical or social work education, and professional embeddedness in primary health and social care institutions. Secondly, the study achieves this by looking specifically at the institutional frame of these professions and not at culture in general.

The analysis offers new insight into images of addiction and therefore provides useful clarification in deciding on phenomenological similarities between different excessive substance consumptions and behaviours, contributing in this way to solving controversies over the concept of addiction. Although this study’s primary focus is not addiction treatment as such, the images of primary health and social care professionals identified in this study can still help to understand why brief interventions (i.e. early identification and brief advice in primary health and social care) remain hard to introduce in some cultural contexts, despite their proven effectiveness in reducing, for example, heavy drinking and obesity and to promoting healthy behaviour in general (e.g. Fleming et al. 1997, Wilk et al. 1997, Deehan et al. 1998, Aalto et al. 2003). Cross-cultural comparative studies taking nations as study units risk replicating stereotypes, explaining cultural differences tautologically by referring to culture and reverting to banal nationalism. This study avoids this trap by understanding culture as consisting of different levels (Sulkunen 2013), particularly looking at the level of the institutional setting, and by using a carefully constructed methodology based on reception studies. In this way, this study is able to produce comparative data between different problems – problem drinking, gambling and eating – and between different contexts, between GPs and SWs, and between the different institutional arrangements of approaching addiction in Finland and France. Thus, this study assists in establishing and testing comparative qualitative instruments between different cultural and institutional contexts and developing theoretical designs able to grasp the complexity of culture.

2 CONCEPTS OF ADDICTION

a. Overview: neurobiology, psychology and rational choice

The present study is a sociological study and neither can nor wants to inquire into a psychological or neurobiological understanding of addiction. However, in order to understand the overall controversy concerning the concept of addiction it is indispensable to give at least an overview of current psychological and neurobiological research. Neurobiological research on addiction basically considers addiction to be a chronic relapsing brain disease (e.g. Kalivas & Volkow 2005). The intake of addictive substances or the conduction of addictive behaviours initiates dopamine release, which is experienced as pleasurable. Having an addiction means that the reward system based in the nucleus accumbens is defective, either by genetic predisposition (e.g. Comings and Blum 2000) and/or changes due to the substance use itself (e.g. Brody et al. 2004, Volkow et al. 2004, Baler & Volkow 2006, Bühler et al. 2010, Bühringer et al. 2012). When engaged too often dopamine receptors lose their sensitivity and a higher amount of substance (or frequency of behaviour) is needed to experience the same high. This also implies that other normally pleasurable activities lose their reward and are consequently valued less compared to the addictive behaviour. The underlying mechanisms of addiction in the brain are interrelated.

The second studied area is the prefrontal cortex, where the cognitive control functions lie. Bühringer et al. (2008) argue that impaired impulse inhibition can be seen in the brain activity and is one explanation why addicts engage in habitual substance abuse instead of following long-term goals. Impulsivity can be generally seen as a risk factor for addictions (Verdejo-Garcia et al. 2008). Still rather weakly studied are memory processes and their physical equivalent in the amygdala and hippocampus. Stacy and Wiers (2010) show that implicit cognition, i.e. memory associations, can trigger substance use instead of making so-called rational decisions. Studying memory in relation to addiction has a long tradition in the psychological field, since learning (e.g. classical or operant conditioning) has been seen as a cause of addiction (Bühringer et al. 2012). A rather new approach in explaining addiction is the emphasis on attentional biases: Not only do drug- and behaviour-related cues directly activate dopamine release, these cues are also more easily discerned by the addicted person (Franken 2003). Moreover, attention towards these cues stays longer than compared to other "natural" cues, such as the smell of food.

The psychologist Robert West (2006) updated the motivational model into a synthetic theory of motivation and established the "prime" model in order to explain addiction. The basic assumption here is that humans have a motivational system, which consists of plans, responses, impulses, motives

and evaluations. The system is very complex and interrelated and consequently the human mind is rather unstable. During evolution the mind has developed correction mechanisms, which hold the mind sane in a similar way to a fly-by-wire system of a modern fighter plane which prevents the aircraft from crashing. Such a theory also includes the finding that traumatic childhood experiences are a risk factor for addiction (Schäfer et al. 2010). Using West's (2006) aeroplane metaphor: if a plane gets into turbulences it is more likely to crash than in calm air. This is rather similar to the explanation of addiction via self-medication; the addict takes the drug in order to fix a problem caused by mental disorders preceding the addiction (e.g. Kanthzian 2003).

Similarly, functional and rational explanations on the one side, and motivational explanations on the other, offer models of rational choice theories which explain how perfectly rational actors can become trapped in an addiction: The value of immediate rewards, like the intoxication feeling, is high, whereas the delayed punishment of a hangover, or the delayed reward of recovery is hyperbolically discounted (e.g. Becker & Murphy 1988, Ainslie 1992).

b. Syndrome theory

Despite progress in psychological and brain research, diagnostic instruments and screening still follow a syndrome theory. The concurrence of several phenomena (Edwards 1986) out of a list have to be fulfilled to become an abuser, or more severely, dependent (e.g. DSM, ICD). The syndromes of (alcohol) dependence are, for example, the subjective feeling of a loss of control, tolerance, withdrawal and continuation despite harmful consequences. However, these syndromes are a mixture of consequences and characteristics of substance dependence (Bühringer et al. 2012), are moral evaluations in medical terminology (Valverde 1998) and carry the risk of being applied carelessly to basically all kinds of excessive and problematic behaviours. Including behavioural problems and problematic eating into the frame of addiction has indeed happened (e.g. Jacobs et al. 1985, Hirschman 1992). Orford (2001) in his book *Excessive Appetites* offers the most comprehensive perspective on addiction as a unitary concept. He includes besides the traditional substance-based addictions, gambling, eating and sports. For him basically every behaviour is an excessive appetite, to which the person has established a strong attachment and which creates a conflict with other needs in this person's life. It exceeds a sensible amount of time and is continued despite harmful consequences (medical, psychological or social). The emphasis lies on the conflict, and therefore this theory also builds an understanding of addiction based on adverse consequences and less on the underlying characteristics of the phenomenon, and refrains from discussing or comprehensively defining the concept of addiction.

c. Disease models

The disease model clearly defines addiction as an illness and starts with the premise that the danger of becoming addicted does not lie in the substance (or behaviour), but in the person him/herself. Some are vulnerable, take up drinking, drink larger amounts, increase their tolerance, lose control, hit rock bottom and manage to become abstinent or die (Fingarette 1988). The main identifying factor is the feeling of loss of control, which is also a major point made by AA, as it often is in public understanding. The scientific foundation of the disease model stems from the 18th century (Ruuska 2013). E.M. Jellinek can be considered one of the most influential addiction researchers in the 20th century and his concept of α - δ alcoholism is probably one reason for the continuing popularity of the disease concept (Jellinek 2010): along with α -type alcoholism is a symptom of another underlying psychological problem and drinking is what Kanthzian (e.g. 2003) later called self-medication. β -type alcoholism, on the other side, is rooted in the heavy drinking customs of a social group and results in physical health problems. γ -type alcoholism is characterised by a loss of control over drinking. Nonetheless, a γ -type alcoholic can abstain for periods of time. In comparison, the δ -type alcoholic drinks daily, but can control the amount drunk. It is not difficult to recognise in the last two types an Anglo-Saxon and French drinking culture and Jellinek (ibid.) makes the point that different drinking cultures produce different alcoholics. He considers only the γ and δ type as diseases, whereas α and β are forms of problematic consumption and symptoms of psychological and social conditions. However, these different types, like the detailed elaboration of alcoholism as a disease, were more or less forgotten and the γ -type drinker became the synonym for the alcoholic, independent of the cultural environment. The main identifier of the alcohol disease, therefore, is loss of control, which also remains the biggest source of criticism. Fingarette (1988: p. 27) points out "that heavy drinking and alcoholism are merely labels that cover a variety of social and personal problems" and Valverde (1998) adds that it is the quantity consumed which matters concerning physical damage and not the feeling of loss of control. However, Ferentzy and Turner (2013) demonstrate that there is no single disease model. Instead, they identify the individual disease model, which is commonly understood as the disease model as described above, and distinguish it from the public health model, which is only seldom recognised as a disease model. The public health model also uses metaphors from medicine, by referring to hosts, agents, the environment and the spread of germs. But, in comparison with the "individual" disease model, the public health approach looks at the aggregate level of addiction problems, also taking into account social factors, but downplaying the individual's problem with the substance or behaviour. In general, the per capita consumption (in the case of substances) and therefore the quantity or frequency is the important factor. The possible problem of the individual in refraining from

the harmful behaviour or consumption is not a matter of concern in the public health model.

d. A pathology of modernity

There are basically two streams of understanding alcoholism and addiction as a phenomenon appearing with the beginning of what is commonly referred to as modernity.² The first considers addiction a new problem caused by the stressful living conditions in contemporary society (e.g. Ehrenberg 2004, Alexander 2000). The other, "Foucauldian" approach, sees addiction as a new way to understand problems, which have existed before and as an expression of a new way of social control (e.g. Ferentzy 2002). This change proceeds from an external social control towards an internalised social control (Foucault 2007, Elias 2005).

Ehrenberg (2004) describes the contemporary world as a place where the pressure on the individual psyche has risen significantly. In comparison to earlier times, where one's course of life was largely determined by birth into a certain feudal group, caste or class, nowadays freedom has grown. Everyone is the architect of his or her own fortune – he/she is free to choose and construct their path of life. However, the price of this freedom is the duty to choose. No matter how big the actual freedom of choice might be for the individual, a failure becomes a matter of individual responsibility and cannot be assigned towards the circumstances. The rising uncertainty and unpredictability of life in modernity further complicates life in the contemporary world. Many can flee these pressures only by substance use, or else they become depressed. Both conditions are sides of the same coin. Alexander (2000) calls this dislocation the insufficient psychosocial integration of the individual caused by the free-market society, where everyone is required to be an individual actor without any bounds. Problematic about this kind of explanation of addiction is the fact that only a minority in contemporary (free-market) societies become addicted. The processes elaborated can only be a part of the description of addiction, as it remains necessary to refer to individual vulnerability towards "severe dislocation" (Alexander 2000) – and therefore to revert to the individual disease model – in order to explain why some become addicted, but the majority remains free of these problems.

In comparison with the "realist" social scientific approach to explaining the appearance of addiction in modernity, which basically accepts the ontological existence of addiction as a new form of problem, others (e.g. Levine 1978, Room 2003, Spode 2005) offer a constructivist perspective.

² It is obvious that modernity is a wide, vague and complex concept. However, in this context an exact definition is unnecessary. Modernity stands here for the period after the transition from a traditional towards a *modern* society described by basically all classical sociologists. This transition is normally placed in the 18th and 19th century for Europe and North America.

Levine (1978) claims that alcohol problems have existed before the birth of an addiction concept. Only in modernity, these problems became conceptualised as a compulsion to drink, and then were called addiction. Whereas before 1880 no vocabulary for a compulsion to drink existed, embedded in an evolving industrial society founded on a Protestant ethic, excessive drinking became a matter of self-control. The importance of self-control is the result of the civilising process (Elias 2005): in the context of rising interdependencies (e.g. the rising division of labour) everyone needed to become aware of the growing chains of interrelations of one's actions. The rightness of one's actions is no longer judged and punished by forces outside the individual, but instead the perpetrator should sit in judgement over him/herself (Foucault 2007). The individuals are governed not against, but through their freedom in order to resolve the paradox between Protestant asceticism and consumerist hedonism (Reith 2004). Ruuska (2013) emphasises that the concept of alcoholism cannot be solely attributed to changing modes of social control: instead it evolved earlier beginning in the 18th century and in a strong relationship with the medical practices and knowledge formation of the medical profession, which turned from bedside to hospital medicine. Bedside medicine involves a wider look at the single (bourgeois) patient including also his social circumstances, whereas hospital medicine concentrates on the body and laboratory data disconnected from the single patient.

e. Addiction – a working perspective

The task of providing a definition of addiction in a study on the concept of addiction is like attempting to pull oneself out of a swamp. The different scientific contemporary concepts presented above offer different suggestions to get out of the swamp, but also show certain limitations.

Jim Orford's (2001) approach towards addiction as excessive appetite and neurobiological studies claiming a similarity between substance and non-substance dependencies (e.g. Comings & Blum 2000), served as a starting point for me to look at problem drinking, gambling and eating under a similar perspective (see also Egerer 2006 concerning drinking and eating). This puts excess and the collision of this excess with other needs into the centre of my early working perspective on addiction. However, I started to doubt the appropriateness of the approach, as it became clear to me that adverse consequences, as real problems as they are, seem problematic in clarifying the concept of addiction (e.g. Bühringer et al. 2012). Neurobiological approaches, which claim to study addiction at its root, on the other hand, neglect the social dimension of addiction and the focus on brain mechanisms unjustly equates reward with motivation (Kalant 2009).

As I elaborated in the introduction, I see addiction as necessarily "running" in the biological system and by psychological mechanisms, but these processes in the body by themselves cannot alone account for

addiction. These bodily experiences have to be interpreted by the individual and by people around, who “refer” to the inter-subjectively shared images of society. I therefore consider addiction a phenomenon that is fundamentally socially constructed. However, in comparison with the earlier social scientific approaches towards addiction I investigate the social construct of addiction not as a result of the worsened psycho-social living conditions of contemporary society (e.g. Alexander 2000, Ehrenberg 2004), or as a new form of internalised and medicalised social control (e.g. Levine 1978, Room 2003, Spode 2005), but from an institutional perspective.

This perspective also demanded a more open conceptualisation of alcohol, gambling and eating “addiction”, which can account equally for individual and societal factors and which describes a continuum rather than the diagnosed either-or categories of normal, abuse and dependence (Pöysti & Majamäki 2012). I therefore shifted during my research process from using the diagnostic term dependence (including alcoholism, pathological gambling and eating disorders) towards problem drinking, gambling and eating. This also enabled me to approach participants’ discussion on these topics more flexibly rather than expecting clear-cut entities.

3 THEORETICAL DESIGN

Institutions are without doubt social constructs and I therefore consider Berger and Luckmann (1967), who described our reality as socially constructed, as most suitable in the context of my study. Social reality is not a ready-made phenomenon given by the (physical) environment, or the physical human body. Instead, humans actively construct the reality they live in. Taking the thought experiment of a group of people stranded on an uninhabited island they follow how a society, its norms and its understanding of the world come into existence. At the beginning there is no tested group experience available (Schütz & Luckmann 2003) and the world around remains a blank slate offering an unlimited number of options, which still need to be understood and categorised. Categories help to span the horizon of possible actions and to know what to expect from situations and conversation partners (Berger & Luckmann 1967). Categories are parts of schemes and scripts, which ease everyday life, as these relieve us from making time- and energy-consuming decisions. Normally, what we do and how we understand the world is taken-for-granted and takes the form of routines and habits. Only when something unexpected happens, breaking the routine, are these new challenges tackled in the light of already available group knowledge.

Existing group knowledge is primarily transmitted during childhood, the first socialisation. Secondary socialisation is a lifelong subsequent process, which is the internalisation of sub-worlds, like for example growing into the life world of the medical profession (e.g. Becker et al. 1961). The life world is the inter-subjectively shared everyday world which individuals face, and which is constantly re-constructed by their interactions and actions. The life world can be therefore understood as the melting point between individual action and societal structures. Berger and Luckmann (1967) discuss this core dualism in sociological enquiries by separating objectification and reification. Whereas people still know how objectified structures came to exist – like the first persons stranded on an island, for example, agree on certain rules – reified structures appear as unalterable towards (later-born) people manifesting their (social) reality. This social being defines human consciousness (ibid.).

However, Lakoff and Johnson (1980, 1999) point out that man's social being is also influenced by his organism: the categories and metaphors we use to understand and describe the world we live in are not arbitrary, but are instead connected with the corporal being of humans. Taking the ability to walk upright as the starting point, social hierarchies are similarly ordered in top-down metaphors (ibid.). The dialectic between organism and social world remains (Berger & Luckmann 1967).

The philosopher Ian Hacking, in *The Social Construction of What?* (1999) offers a solution to this dialectic. He acknowledges the necessity of humans to understand the world they live in. Nonetheless, instead of separating the social and the material world, he develops two possible conceptualisations of the world: indifferent kinds and interactive kinds. Indifferent kinds exist and behave independently of human conceptualisation. For example, salt molecules have a certain atomic structure which reacts with other elements. They have been that way long before humans started to understand and theorise their nature and will be so after humankind has long become extinct. Interactive kinds on the other side describe phenomena that react to whether or how they are understood. Addiction is a point in case: There is no doubt that biochemical processes occur while intoxicated or during withdrawal, which are part of the phenomenon of addiction, but addicts will behave differently depending on whether they are understood as ill, psychopaths or criminals. Similarly, people around will, for example, evade the psychopath, or put the criminal in prison.

Social psychology has conceptualised these processes as attribution. We attribute causes towards our own and other's behaviour, and assign responsibility for them. These explanations either place the behaviour's cause inside or outside the actor, therefore explaining it by personal or situational factors. Attributions are biased and the attributions concerning us tend to differ from the attributions concerning others, as does the attribution of behaviours with a negative or a positive outcome (Malle 2006). Davies (1997) profoundly elaborates that the addiction concept itself is a form of functional attribution, which depends on the context people use (consciously and unconsciously) attributions to explain and justify their, or other's behaviour. He continues by claiming that addiction research fails in misunderstanding these attributions as real causes of addiction and taking the reported loss of control at face value. Instead, loss of control should be understood as a way to construct innocent addicts vs. guilty heavy users, who are responsible for their own and other's misery.

In the interactive kind of addiction, attributions constitute a part of the social environment of heavy users and therefore have an effect on the addict. This, in the end, changes the phenomenon of addiction itself. The phenomenon interactively changes, whereas the indifferent kind would remain the same. This consistent change makes interactive kinds blurry by nature and prototypes (Hacking 1995) help in simplifying the world, keeping some features, but ignoring others. A prototype "is part of what people understand by a concept, what they point to when they want to explain it" (Hacking 1995: p. 34). Each prototype has good examples, which nevertheless does not mean that necessarily all cases are similar. Instead, they show family resemblances. Prototypes classify people, are used to evaluate the unfamiliar, and in this are close to what Moscovici (1984) understands as social representation.

Social representations or images (Boulding 1956) guide the interpretation of new knowledge. I prefer the concept of images in this context, as it describes the perceptive-cognitive moment in action more accurately (Sulkunen 2007). Images are inter-subjectively shared and communication about images themselves is possible (Boulding 1956). Images imply that the beliefs we have of certain behaviours give meaning to these behaviours and at the same time can signify different things (Sulkunen 2007). There are signs of first-order signification, which consist of the signifier, the signified and the interpretant, like, for example, traffic signs. On the other side there are also second-order signs, where the signifier is signified by another sign: Lévi-Strauss (1965), for example identified the underlying structures of mythology giving the example of how images about food practices signify the passage from raw nature (ingredients), to sophisticated culture (cooked meals) back to rotten nature (excrement). A glass of alcohol can be a signifier for the beginning of leisure time, but it can on the second level signify power and gender relations (Sulkunen 2007).

Images are part of the “self-produced web of meaning”, which creates a symbolic system – the life world (Berger & Luckmann 1967) – giving dispositions for action and experiences (Geertz 2011). Images differ from one society to another and in these thought collectives images are exchanged and re-interpreted (Boulding 1956, Moscovici 1984, Douglas 1986). This re-interpretation and exchange also happens on the level of subcultures – like professional groups – which possess their own public image of the world. Public images are similar for all members of the group and serve as procedures of perception, thinking and acting especially in the world important for the subculture. They are subjective, but not individual and are equivalent to what Bourdieu (2009) identifies as the group habitus. Images are fundamentally connected to these group practices. Practices, as “routinized way[s] in which bodies are moved, objects are handled, subjects are treated, things are described and the world is understood” (Reckwitz 2002: p. 250), eventually become bedded down in institutions (Kjaernes et al. 2007).

Gronow (2011) criticises Reckwitz for having a too cognition-based understanding of practices, which comprehends acts as conscious decisions in the first place, which over time become routinised and taken-for-granted; later generations no longer know what have been the initial reasoning for these actions. Gronow (2011) suggests instead the integration of a more action-based view on habits founded in pragmatism. Pragmatist theory considers the act to occur before cognition about it – humans act nearly all the time and then reflect on and try to understand what they have done. Consequently, taken-for-granted practices are not only taken-for-granted, because their initial reasoning has been forgotten, but also because there might never have been an initial conscious reasoning behind these practices.

Institutions are long-lasting disposition repertoires, which are relevant in organising the world for the people in its proximity. Institutions

play an important role in the theoretical design of this dissertation, and the new institutionalism with its emphasis on taken-for-grantedness and unreflectivity is a core part in this enquiry (DiMaggio & Powell 1991a). The thought style in institutions is hardly ever consciously reflected, but is reproduced (Douglas 1986). Nevertheless, institutions always remain a sum of its members, i.e. although people do not normally reflect on institutional scripts and do not question their legitimacy – in fact forgetting the man-made nature of institutions – institutions “run” on individual human beings (Zucker 1991). Therefore, institutional change is possible and happens on the micro level (ibid.). Such a change is, however, seldom guided by rational considerations in order to increase efficiency, but instead copies other (apparently) successful institutions, which leads to a growing isomorphism of institutions (DiMaggio & Powell 1991b).

Based on Bruno Latour’s work on the translation of power (Latour 1986), Czarniawska and Joerges (1996) describe the travelling of ideas from one institution towards another similarly as translation: ideas from another context have to be translated into the new institutional context and cannot therefore be one-to-one exact copies, but instead are interpretations accomplished by already existing images of the world. Ideas do not travel by themselves, but in the mind of people, who understand these in the light of what they already know – similarly, we learn the vocabulary of a foreign language and *interpret* what we hear and read in the light of our own language. These imperfect copying processes also explain change in habits and institutions (Gronow 2011).

The translation of ideas into the new context creates something new. This process is a continuous one, which makes talking of hybrids problematic, since every institution is a hybrid of domesticated ideas (Alasuutari 2013). Also the nation state itself with its institutions has developed over time and by domesticating external and internal ideas. I take nation states (Finland and France) as the framework of comparison, not because I consider these to be solid units (Löfgren 1989), but because they are still the main point of reference for institutions, legislations and the welfare state. My study seeks to avoid banal nationalism, and therefore does not explain differences by nations, but instead participates in the project of developing the concept of geographies, which involves different layers of culture, and thus provides a more accurate perspective on cultural comparisons (Sulkunen 2013). What is important in this study is to identify which ideas and habits have been absorbed into institutions during significant historical periods. The “Sattelzeit”³ of handling alcohol problems and addictions is commonly placed at the beginning of modern nation building and is strongly interconnected with the rise of the welfare state (Spode 2005, Sulkunen 2009). Consequently, the next chapter sheds light

³ Spode (2005) borrows this term from Reinhart Koselleck’s idea of a transition period between early modernity and modernity and applies it to the conceptual history of alcoholism.

on the historical progression of dealing with alcohol and addiction problems during the 20th century.

4 COMPARING FINLAND AND FRANCE

a. The Finnish and French institutional context of handling addiction

Finland and France are both Western, industrialised modern countries and in both the concept of alcohol dependence exists to make sense of repetitive self-harming excessive drinking. Nevertheless, a closer look reveals that the handling of alcohol problems (and following the concept of alcoholism, also other addictions) developed in quite different ways.

Finland is normally referred to as having a “social” approach towards alcoholism (Takala & Lehto 1992, Stenius 2007). One of the reasons for this approach can be seen in the Finnish drinking culture, where alcohol has always been an intoxicant which has been consumed in large quantities at specific times, though rather seldom. This kind of consumption led to particular problems and consequences, such as increased (domestic) violence while intoxicated (Mäkelä & Tigerstedt 1993). Finland became independent in 1917 and therefore it makes sense to start our short tour through Finnish alcohol policy from this year onwards. Between 1919 and 1932 Finland’s alcohol policy was basically limited to total Prohibition, and as a consequence the police and penal institutions handled the issue of alcohol and its problems. Treatment was only provided by temperance-based “refuge” places (called “Turva”) in the countryside, first established in 1888, which placed the emphasis on hard work and moral education (Takala & Lehto 1992).

With the end of prohibition Finland’s alcohol policy had to find new ways to tackle the growing alcohol consumption and its attendant problems (Stenius 2007). The Alcohol Act of 1936 determined to a great extent alcoholism treatment for the following years. Sweden served as a model, with the important difference of using supervision of municipality temperance boards as a compulsory measure (ibid.). These boards were strongly connected to poor relief. This institution came into force in the same year with the introduction of the Welfare Acts (Huoltolait), a starting point for paid social work (Toikko 2005). Before, voluntary laymen ran the poor relief, and exercised “pastoral” power over the needy (Satka 1995). Often wives contacted the municipality temperance boards because their drinking husbands neglected their financial duties towards the family. There was not much change in general in the treatment system until the 1950s and 60s. During this time Jellinek’s disease model (Jellinek 2010) became popular in the Western world.

The founding of the A-Clinic Foundation marked a new chapter in alcohol treatment. This foundation – founded by the Finnish alcohol monopoly Alko – established the A-clinics. This outpatient treatment service adopted the medical vocabulary of the time (clinic, treatment, therapists),

but remained focused on social case work: doctors were only involved part-time in the clinics, nurses handled treatment focused on withdrawal, but did not stay on for night shifts and social workers took the key positions in the A-clinics (Takala & Lehto 1992, Ahonen 2007). In the social work inside the A-clinics, the social casework is separated from legal and financial issues and problems (Toikko 2005). Social workers outside the A-clinics, namely welfare workers, are not included in therapy work, but handle social problems related to alcoholism (Satka 1995, Kallinen-Kräkin 2001). Their duties include supporting the alcoholic's family, granting social benefits and if necessary taking children into custody. The division of labour between social caseworkers and welfare workers was more than merely a functional differentiation, it was also a matter of social workers' identity, where welfare workers did not accept social caseworkers as being the same profession, and vice versa (Satka 1995).

The 70s were influenced by "[a] new generation of alcohol researchers" (Ahonen 2007: p. 161), who favoured a total consumption model: the higher the alcohol consumption of moderate drinkers, the higher the proportion of heavy drinkers inside a population and hence the more severe the alcohol problems found in society (Edwards et al. 1994). Consequently, Finland's alcohol policy became a matter of public health targeting the decrease in alcohol consumption of the whole population. This led to a policy where "[n]orms and ideals are established in the name of public health, regulating the lifestyles of individuals and the behaviour of populations and communities" (Tigerstedt 2001: p. 114). The approach combined universalism and reduced the risk of discriminating against minorities (Sulkunen & Warsell 2012). The focus on a healthy lifestyle remains an important factor in alcohol policy until today. Responsibility is more and more delegated to the citizen (Tigerstedt 2001). Penal institutions have lost their importance in the handling of alcohol problems in Finland and only play a minor role today (Mäkelä & Säilä 1986). An ethic of "not taking a stand" on the side of the state has evolved (Sulkunen 2009). It looks as if the shift from external towards internal control (Elias 2005, Foucault 2007), a core attribute of modernity, has belatedly reached the control of alcohol consumption. This is also the situation in France, but there it arrived from a different direction there.

It might come as a surprise that also in France alcoholism was first seen as a "fléau social", a social plague (Thiry-Bour 1996). Although not yet taken as a medical problem (Mossé 1992), nonetheless, in comparison to Finland notorious drunkards were less likely to be taken to prison than to mental institutions, which were evolving at the same time as a new domain of medicine (Berlivet 2007). In the Nordic countries alcohol policy has been strongly interwoven with general welfare policy (Mäkelä & Tigerstedt 1993). In France, however, alcohol policy remained a project of professionals in the medical field (Mossé 1992). Being a continental power confronted with a faster-growing German population "France's approach to the psy-sciences"

(Ferentzy 2002: p. 167) focused strongly on sex, reproduction and hereditary issues. It does not come as a surprise that the alcohol question was also discussed in this context. Alcoholism stoked fears of depopulation and the fight against alcoholism was also seen as protecting the "French race", as alcoholism was considered to be hereditary (Berlivet 2007). Moreover, the profession of social work developed in this context and included, therefore, strong elements of hygiene and health concerns (e.g. Guerrand & Rupp 1978, Rater-Garcette 1996).

Like Finland in the 1950s and 60s France was influenced by the emerging medical approach of the World Health Organisation. But in comparison to Finland a medical understanding of alcoholism gained a strong foothold in France (Mossé 1992) – after all a medical sector, eager for recognition, has been a strong actor in French alcohol policy (ibid.). Another parallelism with Finland is the emergence of a total consumption model, though it was developed by Sully Ledermann in France a little earlier than in Finland (Berlivet 2007). The main treatment facilities in France up to the 1970s have always been psychiatric institutions, and the paradigm of psychoanalysis has been traditionally strong in France (Bergeron 1999). But at that time these institutions were so crowded that a new form of treatment for alcoholism had to be found (Mossé 1992). Furthermore, inpatient treatment in the psychiatric institutions of this time was questioned as being too repressive and unjustifiably restricted citizen's freedom (Bergeron 2001). The answer was the establishment of the C.H.A. (Centre d'Hygiène Alimentaire) later the C.H.A.A. (Centre d'Hygiène Alimentaire et d'Alcoologie) (Thiry-Bour 1996). These outpatient treatment centres can be compared to the Finnish A-clinics, although the leading position in the C.H.A.A. is taken by the medical profession and social workers only act under the jurisdiction of doctors (ibid.). It is interesting that in both the A-clinics and in the C.H.A.A. there was a wish for a more interdisciplinary alcoholism treatment, although in France they wanted to integrate social work more and stick mainly to the medical profession (ibid.), whereas in Finland more medical expertise was required and social case work remained still the main focus (Ahonen 2007). More recently, the French outpatient system changed to be more in the line with a public health approach and the C.H.A.A. was renamed "Centres de consultation ambulatoire en alcoologie", or CCAA for short (Bergeron 2001).

b. Gambling and eating disorder(s)

Problem gambling was first introduced as a diagnosable pathological condition in the DSM-III in 1980. The moral problem of excessive gambling was turned into a medical one (Castellani 2000, Bernhard 2007). This medicalisation has followed widely the model of alcoholism and is prone to similar criticism (Bernhard 2007). Problem gambling is increasingly seen in the context of addiction (Jacobs et al. 1985, Elster 2003) and understood as

an excessive appetite (Orford 2001). In fact, in the new Diagnostic Manual of Mental Disorders DSM-V, gambling disorders are now part of the "Substance-Related and Addictive Disorders" (APA 2013a). A gambling disorder is confirmed when it fulfils at least four criteria, among which are unsuccessful efforts to control gambling, a need to gamble with growing amounts, or jeopardizing significant relationships or one's occupational career (CAMH 2013). The organisation of treatment of problem gambling is integrated into the addiction treatment system in Finland, but monetary restrictions and the prioritisation of substance-using clients limit places for problem gamblers (Sosiaali- ja Terveysministeriö 2007, Jaakola 2009). In France, on the one hand, the treatment of problem gambling is starting to be linked to the addiction treatment system, but on the other hand, it is still rather restricted to private initiatives, gambler anonymous groups, and a few psychiatric services (Ministère de la Santé et des Solidarités 2007, Valleur 2009). Gambling culture and gambling legislation in Finland and France is the reverse of the drinking culture and alcohol legislation of the two nations. Gambling, for example, is common in Finland and is available at virtually every corner (e.g. Matilainen 2006, Valkama 2006, Jaakola 2009). In France, on the other hand, opportunities to gamble are highly regulated and the French consider games involving money to be a pleasurable time out from ordinary life (e.g. Valleur 2009, Järvinen-Tassopoulos 2009, Pöysti & Majamäki 2013).

According to the DSM-IV-TR (APA 2000) and the ICD-10 (WHO 1992) eating disorders include anorexia, bulimia and binge eating (the last not mentioned in ICD-10). Whereas anorexia is self-induced starving resulting in very low body weight ($BMI \leq 17.5$) (Gerlinghoff & Backmund 2004), bulimics have a strongly alternating, but normal body weight (Gordon 1990). Both eating disorders can involve purging – it is a necessary criterion for bulimia – as well as binge eating episodes with a felt loss of control (APA 2000). Binge eating disorder BED has only been considered a disorder in its own right in the DSM-V (APA 2013b), being identified by binge eating episodes with felt loss of control, but without any inappropriate compensatory behaviours, or self-evaluation by weight and body shape. BED is probably the one eating disorder which most strongly came to be understood as addiction-like (e.g. Orford 2001). Following Orford (2001), this study is interested in bulimia and BED as forms of excessive eating. It is not particularly interested in anorexia, since for anorexia, in contrast to the common understanding of addiction, self-control is part of the problem and not the solution. However, as anorexia is the archetypical eating disorder I expected participants to touch upon this topic as well.

In comparison to the treatment of addictions, the treatment of eating disorders are organised in both Finland and France rather similarly in the medical field, i.e. private and public psychiatric wards, which are sometimes specialised in eating disorders (e.g. Arthuis & Duché 2002, Ministère du travail, de l'emploi et de la Santé 2011, Syömishäiriöliitto 2012). Eating

cultures differ again more in line with drinking cultures, with the “Protestant” Finland having a rather late turn from rural meal norms (e.g. Prättälä & Helminen 1990, Hietala 1997) with a strong emphasis on the nutritional aspects of food, as, for example, in the North Karelia Project (Puska 2002, Fischler & Masson 2008). France, by comparison, is the proverbial country of “haute cuisine”, where eating is a pleasurable activity, which is strongly associated with “convivialité”, i.e. giving a strong social meaning to the meal also in everyday situations (Fischler & Masson 2008).

5 METHOD AND DATA

a. The Reception Analytical Group Interview RAGI

But where does meaning reside after all? In the head of an actor, assigned to the action, or shared by many, i.e. in the culture itself? Surveys start with the notion that meaning resides in actors' minds and that this meaning can be retrieved by asking (Sulkunen & Egerer 2009). Surveys are useful in mapping the distribution of attitudes and images in certain populations (Bauer & Gaskell 2000). This study, however, believes that it is more appropriate to acknowledge that as researchers we cannot find meaning readymade "lying around" somewhere. It is more appropriate to consider research itself to be a part of the continuous interaction of meaning interpretation and reception (Sulkunen & Egerer 2009). The Reception Analytical Group Interview RAGI is a research instrument using stimulated interviews building on the reception of carefully chosen short film clips. Films are cultural products which have to be decoded by the audience. The audience interprets what they see based on what they already know and believe about the world, and by what they comprehend as relevant (Barthes 1977, Fish 1980). Relevance is, however, context dependent, and reception, therefore, is as well (Sulkunen & Egerer 2009). Furthermore, understanding film clips as texts means that they are not empty place markers for audiences' interests and beliefs, but instead, reception is the interaction between the stimulus text and spectators' images (Boulding 1956). Images, as I described earlier, are inter-subjectively shared, and thus creation of meaning during reception is a collective and iterative process (Sulkunen & Egerer 2009). This interaction with others helps us to become aware of our implicit perspectives by explaining and defending our own points of view (Morgan 1997). This process is the core of the RAGI, where the researchers' analysis is a re-interpretation of the variations in reception between the collectively constructed interpretation of the focus groups and the researchers' reading of the stimulus text, i.e. the film clips (Sulkunen & Egerer 2009).

The film clips have been analysed during the development of the interview protocol by using the same semiotic methodology (see chapter 5c), which applies later during the interpretation of the participants' discussion on the stimulus text, i.e. during the analysis of the interview material (Törrönen 2002). Demant (2012) understands focus group interviews as artificial situations where, however, natural interactions occur. The interaction of the informants during the Reception Analytical Group Interview is hardly disturbed by the moderator, as we kept the involvement at a minimum (i.e. only the introduction and explanation of interview modalities and running the clips), in order to enlarge comparability between the groups (Sulkunen & Egerer 2009). The comparability is furthermore

ensured by rigorously following the interview protocol, which clearly lists the order of carefully chosen film clips.

Nine film clips serve in this study as discussion stimuli (working-paper 1.): The stimulus provides the particular and concrete situation of addiction problems and brings non-now, and non-there moments into the presence of the focus group (Merton & Kendall 1946, Törrönen 2002). Three basic categories of alcohol dependence, pathological gambling, and eating disorders adopted from the main diagnostic manuals (DSM-IV-TR and ICD-10) served as the guiding principles for clip selection: loss of control, neglect of duty and cue-dependency/relapse. Although not all of the three phenomena can be identified for all the three disorders, there are striking similarities: The manuals discuss lack of willpower concerning alcohol, imply an impaired control of the pathological gambler and list an irresistible craving for food (WHO 1992, APA 2000). All three phenomena are exemplified by a clip for each problem: alcohol, gambling and eating. Alcohol dependence was chosen, since it is the archetypical addiction and probably the most studied of all addictions. This availability of a huge amount of previous research, offered a good opportunity to evaluate my own methodology and research results. Pathological gambling is probably the behavioural addiction most developed in scientific discourse and it was therefore a natural candidate to be included in my study on the unitary concept of addiction. Eating disorders are normally less associated with addiction than problem drinking and gambling, and their inclusion in my study should be understood as a kind of breaching experiment, challenging informants' addiction images in relation to problem eating (Demant 2012). I limited myself in this study to these three problem behaviours (and did not include smoking) in order to keep the amount of data manageable. I also omitted other substance dependences in order not to open up issues of legality and criminality. Taking three problem behaviours into the research design serves as an instrument to control and cross-check the findings that professionals' images between countries are not merely a reflection of different "realities" of these problems in the different countries, but can be instead analysed as being influenced by different institutional settings and anchored in different cultural images.

The clip selection process happened in close collaboration with colleagues and in the context of a research project about various addictions. We based our initial search on our own knowledge of potentially suitable films, internet search engines, the international movie database (www.imdb.com) and the Finnish Film Archive. We screened altogether 150 movies, which included different substance- and non-substance-based addictions and consumption patterns. 380 scenes from 130 movies qualified as suitable for the project's purpose. The 148 scenes on alcohol, 80 on gambling and 56 on eating were relevant for this study. Of these we selected a number of candidates, which exemplified our three basic parameters (loss of control, neglect of duty, cue-dependency). It is also clear that cinematic

composition and aesthetics are part of constructing addiction images in movies (e.g. Rantala 2013, Egerer & Rantala accepted). However, for the purpose of a group-interview stimulus we considered the artistic components of the clip as part of the “package”; i.e. our semiotic analysis of the clips looked for a portrayal of our three parameters and the portrayal naturally involved cinematic aesthetics. We also wanted the clips to be rather short in order to leave more time for participants’ discussions instead of taking up all the time in showing the stimulus. Furthermore, it was important that the plot could be easily understood and without much dialogue (to limit a translation bias). We also rejected clips with direct displays of violence, and likewise avoided clips from movies with a strong genre (such as Westerns or cartoons) or well-known Hollywood movies. Instead we aimed for rather low-profile films with “realistic” content (Sulkunen & Egerer 2009). Clips fulfilling these prerequisites were presented to different colleagues. Finally, we chose nine film clips, of which we substituted two after the three trial interviews with each 6-10 students. These trials showed that two of the clips were too hard to grasp in the interview situation. Our final selection of film clips is summarised in Table 1. I am aware, of course, of the effect of cultural context and personal bias in the selection of the research material. We tried to enlarge the base of our reception by involving as many researchers in the selection process as possible and by also integrating our international research partners in order to obtain receptions of the clips from different backgrounds. My own institutional context is a Finnish university, but I brought into the clip selection process a prior socialisation based in German culture. I am myself, therefore, a good example of how important it is to look at the cultural context at its different levels.

The clip from *The Happy Alcoholic* makes a good introduction to the theme, as it quite stereotypically portrays an alcoholic’s start of the day, the hidden bottle, and his urge to drink, despite physical discomfort. Dan in *Owning Mahowny* also has an uncontrollable urge, though in his case it is gambling. He wins heavily at a casino table, but continues, losing not only all his money but also the attention of the crowd of spectators around him. The clip presents the problem gambler as an alienated character, losing a struggle of will against the compulsion to gamble. Taina in *Pullahiiri* eats a whole cake alone in her room despite feeling sick. Similar to *The Happy Alcoholic*, secrecy is paired with solitude and a struggle to refrain from harmful consumption.

Neglect of obligation is clearly apparent in *Once Were Warriors*, where Jack spoils the family excursion by getting drunk. In this clip problem drinking is not presented through an inner struggle between will and compulsion, but by focalising (Sulkunen & Törrönen 1997a) on the suffering of Jack’s wife and children. Such a presentation of the negative consequences of problem behaviour is also found in *Bord de mer*: Rose breaks a promise to her son and gambles his inheritance away. This neglect might be less severe

Table 1: Film clips as discussion stimulus

	Alcohol	Gambling	Eating
Loss of control	<i>The Happy Alcoholic</i> (UK: 1984): Alun wakes up with a hangover. He goes down to the yard to get his hidden bottle. He drinks, although he is coughing and choking.	<i>Owning Mahowny</i> (CAN: 2003): Dan Mahowny "busts" the casino table. Later he continues and loses everything. Spectators around him turn away.	<i>Pullahiiri</i> (FIN: 1989): During the night Taina eats a whole cake in her bed. Later she makes herself vomit in the bathroom.
Neglect of duty	<i>Once Were Warriors</i> (NZE: 1994): Jack gets drunk in a bar while his family waits in the car.	<i>Bord de mer</i> (F: 2002): Rose promises to quit gambling when she wins the jackpot. However, she later loses her house and her son's inheritance.	<i>What's Eating Gilbert Grape</i> (USA: 1993): Gilbert's mother is morbidly obese. She tells Gilbert to get his younger brother out of a tree instead of doing it herself.
Cue-dependency/ Relapse	<i>16 Years of Alcohol</i> (UK: 2003): When his girlfriend leaves Frankie, he starts to drink again.	<i>Going for Broke</i> (USA: 2003): While shopping, the fruits in the supermarket remind Laura of slot machines. Afterwards she gambles at the slot machine in the shop. She has no money left to buy her groceries.	<i>I Want Someone to Eat Cheese with</i> (USA: 2006): When his girlfriend leaves James on account of his obesity, he buys sweets and eats them alone.

than in the case of the alcoholic father, but the inversion of the mother-son relation, where the son tells the mother not to continue a certain bad habit, namely gambling, points toward the neglect of maternal duties. Such neglect is more pronounced in *What's Eating Gilbert Grape*, when an obese mother cannot get up to look after her son. Here it becomes clear that it is a matter of

obligation and not of will, since Gilbert's mother is not struggling with her will, but instead is physically incapable of fulfilling her duties as a mother.

Cue-dependency and relapse are, of course, strongly related to will and self-control. However, I introduced this theme as a third category due to its strong position in lay discourse, its frequent reoccurrence in fictional films, but also because it represents the often unsatisfying therapeutic outcome of the professional endeavour to treat addiction (Sulkunen 2007). *16 Years of Alcohol* and *I Want Someone to Eat Cheese with*, both work with the mechanical coping reaction (drinking or eating) of men whose girlfriends leave them (the cue). Taking the reaction itself, it would not qualify as such to indicate problem behaviour. However, in the clip of *16 Years of Alcohol* the inner monologue tells the story of Frankie's struggle not to start drinking again. In *I Want...* the indication of a problem is achieved by contrasting the girlfriend's reason for leaving James – his obesity – with his reaction towards this frustration. This presents a vicious circle, often part of the addiction image. The clip from *Going for Broke* presents the cue-dependency mechanism more straightforwardly. Fruits in a supermarket shelf are enough of a cue to trigger the memory and urge for gambling – Laura, the protagonist finds herself compelled to gamble at the store's slot machine.

The interview protocol of this study lists the clips in the following order: The first set of clips shows *The Happy Alcoholic* and *Owning Mahowny* immediately afterwards, followed by about 20 minutes of discussions. Then *Once Were Warriors* and *Bord de mer* again with about 20 minutes for discussion. The third set also presents clips on alcohol and gambling together (i.e. *16 Years of Alcohol* and *Going for Broke*) with 20 minutes of discussions. The three clips on eating disorders were shown together one after the other. Here time for discussion was also about 20 minutes. This protocol puts the emphasis on alcohol and gambling problems, and keeps eating disorders as a smaller point for discussion. As much as I would have liked to integrate this topic equally, trial interviews showed that in order to keep the time demand for the whole interview within certain limits (90-120 minutes), it was not possible to show one clip with discussions immediately following each of them. The protocol also instructs the moderator not to participate in the discussion and to only intervene if the discourse drifts too far from the topic (which was not necessary in this study).

The following orienting questions lie ready on paper in front of the participants in order to help the participants become oriented towards the topic (Sulkunen & Egerer 2009):

- a. What happens in the scene and who are the persons in the film?
- b. What happened before this event?
- c. What happens immediately after it?
- d. How does the same person appear ten years later?
- e. Can something like this happen in real life?

- f. Should someone do something about the matter shown in the film?

The participants were, however, specifically instructed that they do not need to answer these questions in order, or do not need to answer any of them. Instead we offered the questions to help interviewees get started on their conversation, or to facilitate it in order that the discussion would not become exhausted too quickly. Participants also found a small questionnaire on basic biographical data and a description of the interview setting ready at their place. We videorecorded the focus groups and transcribed the discussions verbatim.

b. Data

The data consists of 27 focus groups with altogether 136 participants (Table 2) gathered between May 2008 and February 2011 in urban centres of Finland and France. The group size varied between two and eight informants. A focus group with only two participants poses limitations, but we conducted the interviews nevertheless rather than sending the interviewees home. The interview duration of these groups did not differ from bigger groups and was in the range of the desired 90-120 minutes. Participants were general practitioners or social workers without special education and experience in the field of addiction.

Table 2: Data

	General practitioners	Social workers
Finland	7 groups (35 participants)	8 groups (31 participants)
France	7 groups (43 participants)	5 groups (27 participants)

The recruitment strategy depended on the institutional organisation of primary health and social services. In Finland the municipalities granted a research permit and we recruited the interviewees by contacting heads of health and social care units. These natural groups were complemented by focus groups gathered via advertisements in social work and medical profession journals. In France, our research partners conducted the interviews by contacting schooling centres for continuous education in medicine and heads of social offices. Consequently, French GPs did not know their focus group members very well; social workers, on the other hand, did know their colleagues.

The social workers who participated, were mainly women (Finland: 27/31; France: 26/27) – this reflects the sex ratio of the social services in both countries (THL 2009, Bessin 2005). The majority of participating Finnish GPs were also female (23/35), whereas more male physicians took part in France (27/43). This, again, mirrors the actual gender distribution of

GPs in Finland and France (INSEE 2010, Suomen Lääkäriliito 2010). Most of the participating Finnish social workers worked in adult social work and family services, whereas their French colleagues worked in the health and disability area, and in general social work. The GP informants in France (median: 54 years; four participants did not indicate their age) were slightly older than in Finland (median: 50 years). Conversely, the participating French social workers were younger (median: 38 years) than the interviewees in Finland (median: 46 years).

c. Analysis of interview discussions

I analysed the transcripts of all interviews in their original language. Atlas.ti (sub-study II. and III.) and MaxQda (sub-study IV.) software helped in organising the analysis. One of my colleagues coded five of the Finnish interviews independently in order to test the reliability of my coding. Only minor differences appeared. Our French project partners conducted an analysis of the French (GP) material on their own and came to similar conclusions like I did (Mougin 2010).

In all three sub-studies the analysis followed a three-step approach.

First “sociological constructed codes” (Strauss 1987: p. 33) helped to organise the interview material. In sub-studies II. and III. I chose as codes the common distribution between biological, psychological and social consequences and reasons for the addiction. In addition, I coded the material depending on where the interviewees saw responsibilities and possibilities for handling the problem: did they consider medical treatment, psychotherapy, or for example self-help groups as actors in dealing with addictions. These “constructed” categories were further divided depending on whether the informants stressed the environment or the person in their discussions. The social consequences were, for example, discussed via the harm towards the family, or the indebted gambler. The reasons can e.g. be placed in society or the genes of the drinker, i.e. the reasons are attributed as external or internal (Davies 1997). In sub-study IV., I used different codes for organising the interview material. There I used five broad categories as indicators of the impact of the different cultural levels I enquired: a. who is harmed by the problem behaviour (i.e. problem drinking, gambling and eating), b. the interviewee’s own position in treatment, c. what is the root of the problem, d. who is responsible for solving the problem, and e. what is the explanation for the problem behaviour.

After this first step, a second surveying step (Silverman 2001) followed in all three sub-studies. In this phase of the analysis I compared the number of quotations between the different codes in order to get an overview of the topics the informants paid attention to. This step also offered a group-to-group validation and ensured that the frequent occurrence of one topic is not due to particular group dynamics or is true of only one or two groups

(Morgan 1997). One quotation consisted of one uninterrupted statement of an interviewee in the discussion. The length of the quotations could therefore vary a great deal. This intermediate step had to be followed by the thorough (semiotic) analysis of step three, as the number of quotations concerning a certain topic does not indicate how important the topic is and does not explain what kind of addiction image the study participants re-create in their discourse.

The discourse which evolved during the focus group interviews is a co-operatively produced reception by the interviewees of the stimulus text. The text (stimulus text and interview discourse alike) can be understood as a narrative and be analytically separated into two dimensions (Sulkunen & Törrönen 1997a, 1997b, Törrönen 2002): The dimension of utterance concerns the plain story which is told by someone. The position of the storyteller towards his/her told content can be called the enunciative dimension. In the enunciative dimension the speaker evaluates what he/she is telling: for example an interviewee can tell about his/her patient or client who has a drinking problem (dimension of utterance) and at the same time position him/herself towards the narrative by stating how angry this drinker's violent behaviour makes the interviewee (dimension of enunciation).

The interviewee takes an actant position in the narrative. The actant model provides a structure to reduce all the actors appearing in a story to an actant and therefore, to evaluate their relations towards each other (Greimas 1971, Greimas 1988). The actant model, initially distilled from Russian folk stories, has a subject, an object, a sender, a receiver, a helper, an opponent, and an anti-subject (Sulkunen & Törrönen 1997a, 1997b). Taking the example of a stereotypical fairy tale probably best explains the different actants in a dimension of utterance: The subject is the hero, who is sent by the wise king (sender) to save the kingdom (object). With his magical sword (helper) the hero slays the dragon (opponent) and triumphs over evil (anti-subject). Saving the kingdom, the hero gains the princess as a reward and they and the kingdom's people (receiver) live happily ever after. Actant positions are not exclusive and characters can take different positions during the narrative; also, not all actant positions need to be filled in every story. In a fairy tale the speaker is often a zero degree enunciator, i.e. hidden and neutrally telling the story (Sulkunen & Törrönen 1997a, 1997b).

A more illustrative example of the actant positions on the dimension of enunciation is a political documentary, where the journalist takes the subject position (also the sender at the same time), who sets out to find out the (often ugly) truth (object) about a company (anti-subject). After some struggles with company lawyers (opponents) the journalist finds someone inside the company to help him (helper) get hold of compromising data to uncover the company's illegal activities. The general public (receiver) is now able to avoid this company's services (also Sulkunen & Törrönen 1997b).

The two dimensions are connected by “projections”, which engage the feelings or characteristics of actors in the story towards the speaker (ibid.). Projections also create motivation to follow the narrative as a spectator/listener and they construct a sense of trust between the speaker and the audience (ibid.). For example the journalist might use phrases like “we all know...” which connects the speaker with the audience. The audience needs to be persuaded by the speaker’s credibility; this is achieved by “modalities” (Sulkunen & Törrönen 1997b). Veridictory modalities put the speaker and the addressee into the same position, which creates a sense of solidarity between the two. Epistemic modalities, on the other hand, create trust through the superiority of the speaker; here he/she evaluates and explains the world to us, like authors often do in scientific texts. A third group of modalities also appears in texts, namely pragmatic modalities. Pragmatic modalities do not assess the certainty of what is told in the dimension of utterance, but instead “qualify the value of doing or being something” (Sulkunen & Törrönen 1997a: p. 57).

An actant’s doing can be qualified as positive or negative by using one of the four pragmatic modalities: will, competence, obligation and ability. These can be actualised in the story, or can fail to be actualised. Will and competence present the acts as coming from within the actant. Obligation and ability are placed onto the actant from the outside. The actant can have the will to withstand the urge to drink, or not. In fact, in films about alcoholism, the drinking protagonist’s will, or lack of will, is the main vehicle to present the drinking as an addiction – only the pure will saves the protagonist from declining and lack of it ends in not achieving the desired object (Sulkunen 2007). Neglect of one’s obligation is also used in television dramas to construct drinking as alcoholism – as soon as the drinking interferes with work, or harms the family the drinker is presented as an alcoholic, which also often results in changed relations between the different characters of the story (e.g. working-paper I., Egerer 2006). Pragmatic modalities, therefore, also define the relationships between different characters in a story. For example, when one of the interviewed social workers discusses the clip from *Going for Broke*, they understand the gambling mother as neglecting her obligation towards her children. The children are here the targets of what is called focalisation (Sulkunen & Törrönen 1997a, 1997b).

Focalisation describes the process by which the speaker fixes attention on a particular character or characters. The perspective onto the narrative depends on whom the speaker focalises: In the example above, the neglect of maternal obligation (to buy food for the children) is narrated as being felt by the children and not by the mother. The focalisation would have been on the mother if the interviewee had told about the mother’s despair at not being able to provide for her children because of her gambling.

6 RESULTS

In the three sub-studies, I could identify that the institutional organisation of dealing with addictions and the institutional organisation of primary health care and social services leave their mark on the addiction image of general practitioners and social workers. These institutional footprints could be tracked down in five themes (Table 3). In the following I will explain these themes and present how the identified images reflect the institutional contexts of GPs and SWs in Finland and France.

Table 3: Combined results of all three sub-studies

	Alcohol				Gambling		Eating	
	Finland		France		FIN	FR	FIN	FR
Professional group	SW	GP	SW	GP	SW	SW	SW	SW
Profession feels responsible in treatment	No	No	Yes	Yes	(No)	No	No	No
Harm to	Others	Others	Self	Self	Others	Self	Others	Both
Responsibility for recovery	Self	Self	Self	Self	Self	Others	Not discussed	Self
Root of problem	Social		Individual		Social	Social	Social	No/Individual
Explanation of problem	Functional		Functional		Functional	No	Functional	Functional

a. Role of profession in treating problem drinking, gambling and eating

The traditional role of GPs and social workers concerning the treatment of addiction itself varies strongly between Finland and France and the two professions are differently involved in handling these problems (see section 4a). The traces of this institutional context could be identified in the addiction images in all three sub-studies.

Sub-study II. explores the problem drinking images of GPs in Finland and France in the light of more uniform alcohol policies in Europe (Österberg & Karlsson 2002), and the growing involvement of primary healthcare in handling addictions, namely by brief interventions. Brief interventions in GPs' offices, i.e. the early identification and short advice for problem drinkers, have been proven to be effective in reducing alcohol

consumption (e.g. Fleming et al. 1997). Despite these tendencies and the effectiveness of brief interventions, implementation in GPs' offices remains difficult (e.g. Deehan et al. 1998, Aalto et al. 2003). I explain part of the difficulties of implementing this treatment form by showing how the interviewed Finnish GPs replicate their traditionally weak role in addiction treatment. French GPs, on the other hand, may acknowledge difficulties with drinking patients, but nevertheless point out the responsibility of helping their patients with all their problems.

Drinking problems changed from being moral problems to being a medical issue (e.g. Levine 1978). Medicalisation, however, as Conrad and Schneider (1980) argue, happens on three different levels. The conceptual level, when the medical vocabulary serves to describe the problem; the institutional level, where medical professionals become the supervising agents of the institutions handling the medicalised problem; and, the doctor-patient level, which is reached when physicians apply routine medical treatment to the problem. Drinking problems in Finland and France are both clearly medicalised on the conceptual level, with health insurance covering treatment, using diagnostic manuals for identification (e.g. the International Classification of Diseases) or, for example, by calling the outpatient units "A-clinics" (in Finland). However, when looking at the institutional level, this picture becomes more complex: The Finnish A-clinics are not led by the medical profession, but by specialised social workers (Ahonen 2007), whereas the French C.H.A.A. (nowadays called CCAA) often have medical doctors as their head (Thiry-Bour 1996). In France, Voilquin (1988) considered GPs to be the main actors in addiction treatment on the doctor-patient level.

Indeed, French GPs discussed their role in helping the drinker with his/her drinking problem more empathically than their Finnish colleagues. They talked in terms of "I" and "we" when discussing the GPs' obligation to help their patients with their problem drinking. They also remain the subject in their narratives on the complicated work of handling heavy drinkers in their daily practice. Finnish GPs, on the other hand, might also discuss medical help for problem drinkers, like medication, but are critical, because they can only treat the symptoms of heavy drinking. If the drinker does not quit, or at least does not limit his/her drinking, the GPs experience their intervention as in vain. In only a few cases do Finnish GPs evaluate their possibilities of doing something more than just treating the negative (bodily) consequences of heavy drinking. They remain distanced in their narrative by, for example, not using the first person in the way their French colleagues do and by discussing the possibilities of GPs on a general level. The problem drinking image identified in the two countries hints towards a medicalisation of problem drinking down to the doctor-patient level in France; though not in the case of Finland. I conclude in sub-study II. that the implementation of treatment measures involving routine medical treatment in the GP's office, like brief interventions, might not only be hindered by practical issues, like

missing reimbursement and limited consultation time, but also by persistent images of one's own professional role concerning dealing with addictions.

In sub-study III. I investigated what problem drinking images Finnish social workers express in the light of contradictory demands between their task to secure wellbeing for the weakest members of the welfare state and the autonomy of citizens. Citizen autonomy has been identified as one of the leading principles of social inclusion today (Sulkunen 2009) and social workers are therefore expected to pay special attention to this issue. The participating Finnish social workers resolve the dilemma by constructing two different narratives with different actant constellations involving themselves and the problem drinker.

There are two kinds of problem drinkers for Finnish social workers. In their first narrative, the interviewees construct an alliance between themselves and the heavy drinker, by talking of "you", a person who needs medication, and acknowledging that "we" can all be weak. The heavy drinker is the subject in this first narrative. The story's helpers are the social workers, who can support the heavy drinker by "offering something" and by suggesting different things as alternatives to drinking. The social workers specifically consider it to be their obligation to do something and to "see beyond the alcoholic person, in spite of the odour". However, this help remains restricted to the negative social consequences of drinking, which becomes especially obvious in the second story on the problem drinker. In this narrative the social worker becomes the subject who protects innocent children from the alcoholic. The alcoholic's drinking, now discussed in terms of risk and harm, becomes the opponent. Against this foe, the social workers are willing to violate citizen autonomy in order to fulfil the promise of the traditional pastoral welfare state, where the good shepherd leads the lost sheep back to his flock – maybe against his will, but for his own good. In sub-study III., my co-authors and I interpret these two stories as a reflection of the history of the social work profession in Finland. In comparison to the social case workers, who are specialists in addiction treatment, the welfare workers we interviewed have their place in the administration of welfare offices, like general social care and child protection (Satka 1995). In this context, guidance and control are understood as a way to prevent alcohol problems, at least in the following generation.

Sub-study IV. continues directly with the results of sub-study III. by comparing these results with French social workers' problem drinking images and widens the scope by enquiring in what way problem gambling and problem eating images are similar, and how these images are connected to the different levels of a culture (Sulkunen 2013).

In contrast to the hypotheses that under the influence of the French medical model of addiction (e.g. Bergeron 1999), French social workers would not feel responsible for treating problem drinking itself, the French study participants are more eager to do so, when compared with their Finnish colleagues. However, French and Finnish participants were similar

in distinguishing between deserving and non-deserving drinkers. French informants became emotionally involved when discussing the clip of *Once Were Warriors* and therefore when the discourse was concerned about the harm towards the family – just like in the Finnish social workers' focus groups. I will discuss this unexpected finding later and in relation with the focalisation on the suffering drinker in France (see section 6b).

In France and Finland, problem gambling is handled mainly in the context of addiction treatment. The treatment organisation and treatment professionals are therefore similar to dealing with problem drinking. In sub-study IV., I found that Finnish social workers also expressed a similar understanding of their role concerning problem gambling. Social workers do not discuss the treatment of pathological or addictive gambling as part of their duty. However, the Finnish informants talked about helping the individual gambler with his/her problems caused by excessive gambling, and supported the idea of limiting gamblers' financial autonomy by having their bank accounts run by the social office. Here social workers' intervention tackles, as with alcohol dependence, the symptoms of the disorder; nonetheless, the client is not the drinker's family which needs protecting, but the gambler him-/herself. Gambling appeared in French social workers' focus groups to be very different from problem drinking. These French participants did not discuss a role for their profession in the treatment of problem gambling, and only saw a marginal possibility of being involved in the prevention of this problem.

In both countries, the strong anchoring of the treatment of eating disorders in the medical field is also reflected in the social workers' debate on this issue. Neither Finnish nor French social workers eagerly discussed the recovery from eating disorders and neither of them saw an obligation or a possibility to help the problem eater. This might not only be due to the interview protocol, which gave less space for the discussion of problem eating, but also to the fact that almost none of the informants told about having had experience of the problem in their client contacts. However, Finnish social workers started to review their involvement in the case where others, i.e. the family, suffered from the problem eating of one of its members, as in the clip from *What's Eating Gilbert Grape*. This focalisation on the harm caused by the problem behaviour will be also the topic of the following section.

b. Harm caused by problem drinking, gambling and eating

One of the main identifiers of addiction and addiction-like behaviours is the harm they cause (e.g. AUDIT, SOGS, DSM, ICD). However, the ascription of especially social harms remains difficult and highly normative (Room 2000). As I presented in Chapter 4a, Finland and France are examples of different ways of conceptualising and framing problem drinking and other addictions. Finland with its non-medical model understands problem

drinking in social terms, whereas the traditional French medical model looks at the physical damage done by drinking (e.g. Bruun 1971, Bergeron 1999).

In the interview material this framing was clearly obvious in all three sub-studies. In fact, the focalisation on the victim of the harm caused by the problem behaviour was the most congruent result when comparing Finnish with French informants (GPs and SWs alike). Finnish GPs and social workers focalised on the suffering family of the problem drinker, gambler and eater. This means they interpreted the harm (done by drinking, gambling and eating) through the eyes of the other. The neglect of the other was the theme in three of the stimulus clips, but the Finnish interviewees did not only refer to these clips when taking the position of the suffering family. Some social workers, for example, worried about hungry children in the *Going for Broke* clip on cue-dependency, and other GPs wondered whether unemployment benefits could help Frankie in *16 Years of Alcohol*. In general, both GPs and SWs discussed all three problems in the context of the welfare state. Although the French welfare state has a financial burden because of the three problems, the French informants were nevertheless more concerned with individual suffering, and even the drinking father (*Once Were Warriors*) evoked images of individual poverty and homelessness. Individual suffering, be it physical (e.g. coughing or cirrhosis of the liver) or social (e.g. poverty or imprisonment) was the focus of the French participants.

The only partial exception was the French social workers in their discussion of problem eating, where they also discussed the harm the obese mother in *What's Eating Gilbert Grape* caused her children. They used the same analogy as their Finnish colleagues and compared the mother with a bee queen in the hive, controlling and exploiting the family. However, they also empathised with the suffering mother in a stronger way than the Finnish social workers. It would seem that although problem eating is not integrated into the addiction treatment in the two countries, the traditional institutional framing (non-medical in Finland and medical in France) served for the participants to make sense of the three disorders. Social eating has an important place in the French food culture (Fischler & Masson 2008), and this might explain the slightly diverging problem eating image expressed by the French social workers. French social workers diverge also on their role perception concerning problem drinking (see section 6a). In sub-study IV., I suggested that with the focalisation on the suffering individual drinker also comes a stronger identification with the drinker, which might create the wish to help the drinker directly.

There are different levels of culture involved in forming this image of the suffering individual (France) and the suffering other (Finland). Besides the traditional approach towards addiction in the two countries, in sub-study II. I investigated the organisation of primary health care, which differs significantly between Finland and France. The French organisation of primary health care, with private GP offices and often longer and deeper doctor-patient relationships than in the Finnish health centre system might

also play a role in focusing on the suffering patient. Bloy (2010) exemplifies how eager French GPs are to talk of “my patient”.

In sub-study III. the focus of the Finnish SWs on the social harm done by the drinker quite clearly reflects their position in the welfare state. In comparison with the social case workers in addiction treatment, the interviewed welfare workers’ daily work concerns exactly these negative consequences of problem drinking. Sub-study IV., however, demanded a re-interpretation of the conclusions of sub-study II. and III. The institutional work context of the social workers does not differ as strongly as the work organisation of the GPs (with private offices and health centres), but the SWs nevertheless differ in their focalisation of harm. One explanation I offer in sub-study IV. is that in the less traditional Finland (Inglehart 1997) intrusion into another person’s integrity is less acceptable, as it constitutes a threat to the social order (Sulkunen 2009). Another institutional influence on the focalisation of harm could be the different history of professionalisation of social work, which is linked with health and hygiene in France and more with poverty in Finland (e.g. Guerrand & Rupp 1978, Toikko 2005). Also, the different composition of the samples, with the participating French social workers coming more from “individual” based services (health and disability) than the Finnish, might have had an impact on this image expression.

c. Responsibility for recovery

Brickman and colleagues (1982) distinguish between the responsibility for the occurrence of a problem and the responsibility for recovery. The four models of helping and coping are the moral model, where the person is responsible for the problem and its recovery; the compensatory model, where the person is responsible for the recovery, but not for the problem itself; the enlightenment model, where the person is responsible for his/her problem, but not for solving it; and the medical model, where the patient is neither responsible for the problem, nor the recovery. Recovery from the problem depends on the ability to self-change, which on the other hand need not be connected to the ascription of responsibility to do so: There remains a difference concerning who is considered to be responsible to act and who is able to solve the problem (Koski-Jännes et al. 2012).

As I showed in section 6a, GPs and SWs in France and Finland differ in their role perception of involvement in the treatment of addictions. Whereas the Finnish participants doubted whether they could play a part in solving addiction (drinking, gambling and eating) and questioned their responsibility to do so, the French interviewees saw their responsibility as helping the problem drinker. They were, however, at the same time critical of their abilities to solve problem drinking. When looking now at who the study participants deemed were responsible for acting concerning the problem, my analysis in all three sub-studies showed that all French and Finnish focus groups discussed the problem drinker as being personally responsible for

acting on his/her problem. As I elaborated in section 2d, addiction can be understood as a pathology of modernity (e.g. Levine 1978), where the need for self-control becomes paramount. From this perspective problem drinking was an addiction in the eyes of the participants.

Sub-study IV. revealed, however, that when widening the angle to include non-substance-based addictions and addiction-like behaviours, the picture becomes more complicated – at least in the French case. French social workers also considered problem eating to be a matter that the eater him-/herself should take care of. Only in the case of teenagers and children, i.e. when discussing the clip on the teenage girl in *Pullahiiri*, was their verdict less austere. In comparison, they did not demand in their discussions that the problem gambler should be responsible for his/her own recovery.

In earlier studies on population and professionals' addiction images (Blomqvist 2009, Hirschovits-Gerz et al. 2012, Hirschovits-Gerz 2013) substance-based addictions (with the exception of tobacco) have always been identified as being perceived as harder to quit than behavioural addictions. In the French context this hierarchy of easy to quit habits and hard substance-induced addictions could not be replicated, and the problem gambling image stands out as an exception in several respects (see also the following section) in France. In Finland, on the other hand, the interviewed social workers held the gambler responsible as the main actor to do something about his/her problem and in this they reflected the problem drinking image and Finnish "individualism" (Hirschovits-Gerz et al. 2011, Sulkunen 2013). Even in comparison with their Swedish neighbours, the Finnish population strongly trusted in and demanded the individual's "sisu", i.e. the personal (will) power to overcome life's hardships (Hirschovits-Gerz et al. 2011). The Finnish social workers generally did not discuss personal involvement in recovery from problem eating, but overall excluded this topic from their debate.

d. The root and explanation of problem drinking, gambling and eating

In this dissertation I studied the theme of the root and explanation of problem drinking only in sub-study III. and IV., and therefore, only the social workers' images are available. The non-medical and medical model of addiction (as described above) places the root of addiction either in the social, or in the body (of the individual). This, however, does not necessarily involve also an ascription of responsibility for the problem, since the source of the problem may lie in the person (or in society), but the interviewees' narrative may either construct the addict as responsible for losing the inner struggle (or coping wrongly with the circumstances), or as an innocent victim of a disease (or a bad childhood). Although the discourse about the reason of the problem often involves a (causal) explanation, other "inventories of

speech" like classifications and memories also serve in constructing social behaviour in the discussions (Sulkunen 1992).

In the context of the Finnish non-medical model, the social workers widely discussed the root of the three problems in the social realm. The informants regret the fading influence of the welfare state and accuse the dislocating modern society (Alexander 2000) of being the root of the problem. In such a stressful environment, where the individual lacks a sense of psychosocial integration many have learned inappropriate coping mechanisms for handling pressure in Western capitalist countries (Ehrenberg 2004, Alexander 2000). This also includes a functional explanation of the three problems. In the focus group discussions the Finnish social workers constructed a causal relation between modern society and the appearance of problem drinking, gambling and eating (which does not necessarily need to be the "real" causal mechanism (Davies 1997)).

I could also spot such an attribution in the French material, when the social workers debated problem drinking and eating. However, they followed the medical model in seeing the root of these problems as being within the problem drinker and eater him-/herself. An inherent weakness or disease causes the problematic behaviour and not a dislocating society. Drinkers and over-eaters – as unacceptable as overeating might be for the social workers – are self-medicating (see e.g. Khantzian 2003); their condition is an inner flaw for which they are, however, not responsible. In the terms of Brickman and colleagues (1982), French and Finnish social workers hold a compensatory model for problem drinking, either excusing the drunkard from the circumstances or a disease, but demanding from him/her to act on the problem.

This model also holds for problem gambling and eating according to the responses of Finnish informants. The French social workers, however, expressed a surprising problem gambling image: they framed problem gambling within a social dimension, discussing it in terms of state regulations and casino greed. They used a discourse of availability, which is similar to their Finnish colleagues when talking about alcohol. Pöysti (accepted) explains that in the more regulated French gambling context, recreational gamblers demand more regulations, whereas in the more liberal Finnish context, such a wish is less expressed. French social workers seem to express a similar concern concerning the lack of regulation.

Furthermore, although French social workers saw the root of problem gambling in inadequate regulation and prevention, and glamorous media images, in their discussions they did not construct a causal explanation between these societal factors and the occurrence of problem gambling. Instead they told how the temptation for a gambling thrill could lure individuals, including themselves, into destruction. The thrill of gambling seems to be thoroughly understandable for our French participants and therefore they saw no need to explain the occurrence of problem gambling. The reason why people gambled and why they might start to gamble with too

Results

much money seemed to be apparent to them from the very beginning and needed no explanation in their discussions.

7 CONCLUSIONS

In this dissertation I demonstrated the importance of the institutional context for addiction images.

1. Finnish and French GPs understand alcohol dependence by following their country's traditional approach towards alcohol as either a social, or an individual medical problem. Also, their role perception in the treatment of alcohol dependence reflects their traditional position, as Finnish GPs question their part in treating alcohol dependence itself, whereas French GPs acknowledge an obligation to help their patients with their addiction.
2. Finnish social workers conceptualise problem drinking in a social framework, hence replicating the traditional Finnish approach. They draw a line between heavy drinking and alcohol dependence by identification with the heavy drinkers and their inappropriate coping strategy, on the one hand, and, on the other hand, by discussing those who are alcohol dependent in terms of risk and harm towards the family. The family's wellbeing is the deciding factor for social worker's involvement in handling problem drinking.
3. Finnish social workers use their country's traditional approach towards addiction as a model for problem gambling and eating. French social workers', on the other hand, portray a more diverse picture and conceptualise problem gambling not by replicating the French approach towards addiction, but instead showing here similarities towards the Finnish approach towards problem drinking.

The traditional Finnish or French approach towards alcohol problems seems to be the most important factor in forming addiction images, but is not the only disposition for interpretation triggered by the stimulus clips. The different organisation of primary health care in the two countries might also play a part in forming the problem drinking images. The problem drinking prototype (Hacking 1995) for French GPs maintains concentration on the single patient, resembling the practice of primary health care in France. It tends to "ignore" (or at least regard less) the social problems involved. Finnish GPs' medical practice within the context of the welfare state reacts to drinking problems by following a social framework. Also the problem drinking images of Finnish social workers reflect both the Finnish approach towards addiction and their profession's historical position as welfare agents in the welfare state, as compared to being therapists giving treatment. Such a resemblance of professional practices with addiction images was earlier identified by Pennonen and Koski-Jännes (2010), who showed that different professions, even though all involved in treatment, express a different

ascription of responsibility of addicts for their problem and recovery. This study confirms Davies' (1997) claim that the kind of attribution (here: external or internal) is influenced by "major structural components" and is influenced by the dispositions given by institutions. These dispositions include the (medical and social work) profession's history, the organisation of primary health care, and the approach towards addiction manifested in the task division between professions concerning citizens' welfare.

Furthermore, sub-study IV. revealed that the institutional context involves not only the country-specific approach towards addiction, the organisation of primary health care and a profession's history, but also gambling legislation. Like Pöysti (accepted), I could also identify in my interview material that in the context of the relatively restrictive French gambling legislation, French informants "use" this setting for understanding the rather new phenomenon of problem gambling. They do, however, nevertheless focus on the suffering individual gambler in a similar way to focalising on the drinker. This pattern of focalisation might hint to another – deeper – level of culture, like underlying values such as the degree of individualism (Hirschovits-Gerz et al. 2011, Sulkunen 2013). In the case of problem eating, French eating practices – which place a high significance on the social nature of the meal (Fischler & Masson 2008) – influence the interpretation of problematic eating and lead to a more critical view of the problem eater. Likewise, we can expect country-specific gambling practices to play a role in the interpretation of problem gambling.

These results illustrate how the focus-group participants used their existing images to interpret the film clips and the problems involved. It shows how their institutions' dispositions are especially potent in structuring participants' perception of the world. Institutions are what Berger and Luckmann (1967) call reified structures: the inhabitants of the life world experience these structures as an unalterable part of social reality. This study hopes that unveiling these mechanisms in the case of addiction offers a possibility for reflection and an opportunity to question the inalterability of institutional dispositions, presenting them as interactive kinds in Hacking's (1999) sense. The possibility for such a reflection seems to me especially important for the persons concerned –problem drinkers, gamblers and eaters. Neither the Finnish nor the French framing of the three problems should be regarded as better. Instead they entail certain advantages as well as risks: In Finland the social framework might be an advantage for the drinker's family to get help more easily. On the other hand, in this context the problem drinker (gambler, or eater) might be more easily led to neutralise his/her wrongdoings by blaming his/her unfortunate societal circumstances for his condition. The concentration on the individual drinker and eater in France, by comparison, might promote more adequate help for the person concerned, but might end in neglecting strategies targeted at the social circumstance.

Furthermore, the study hints towards which images play a bigger role and for which problem behaviour. The question is now why in the Finnish context the traditional approach towards addiction plays a greater part in conceptualising the three problems than it does in the French sample. It seems that the French medical framing of addiction does not fit as well to explain problem gambling as the Finnish social framing does, and therefore replicating the image of addiction would become rather difficult. This could explain why the French participants needed to “refer” to the cultural level of gambling legislation in order to have ready dispositions to react towards the gambling problems shown in the stimulus clips.

Like all studies, this research has its limitations. The sample of GPs and SWs is fairly small and originates mainly from the urban centres of Finland and France. This kind of limitation in generalisability is common in qualitative research, which looks for typologies and characteristics rather than distributions. The methodology based on informants’ reception only analyses images and not the actual praxis. It is a basic assumption in the theoretical framework of images and social representations that the verbal statement and behaviour are two sides of the same coin, and are therefore similar (Wagner 1994), but this theoretical claim needs empirical confirmation in future studies. Finally, the social constructivist theoretical design chosen in order to focus on institutions is inherently conservative by assuming the persistence of collective images and institutional arrangements. The individual actor remains quite powerless. The price of my approach is therefore to disregard to some degree the conflicts and tensions on the micro-level inside institutions and to place only low belief in individual agency. It also limits the view on the tensions between institutions, namely the hierarchy between the (more powerful) medical and the (weaker) social profession, which should be the focus of research to come.

Keeping these limitations in mind, the conclusions made on the basis of the results of this dissertation nevertheless hold important theoretical, methodological and practical implications for addiction research and beyond.

Many scientific disciplines contribute towards explaining addiction. There are (neuro)biological, psychological and rational choice approaches, syndrome theories, and disease models, which all have their strengths and weaknesses. Social scientific approaches have criticised these approaches, especially for their blindness to the social context in creating the addiction problem, but also in forming the understanding of addiction itself. The scientific gaze itself is a product of the social context. Acknowledging this context is important beyond academic discourse, as the concept of addiction is an interactive kind (Hacking 1999) and hence is part of the phenomenon of addiction. However, sociological inquiries on the concept of addiction, have so far largely missed tackling the social setting beyond the internalisation of social control and power relations in modernity. The present study started to open the closed black box that the social setting has often been. Tracing

institutional footprints in general practitioners' and social workers' addiction images demonstrates that the social construct of addiction is more than a new form of social control of modernity or a consequence of psychosocial dislocation in contemporary society. Instead, it is also the construct of institutional contexts.

The starting point of my enquiries on addiction was Jim Orford's (2001) *Excessive Appetites* (see also Egerer 2006), and was therefore a unitary concept of addiction. My growing discomfort with this approach while working on the issue are substantiated by the results of my study: The complexity and diversity of the participants' images of the three problems makes a concrete umbrella concept of addiction questionable. Addiction is not only culture bound (Room 1985, Davies 1997), but also culture-level bound. The varying degrees and combinations of institutional settings between countries, like legislations (e.g. gambling monopolies), health care arrangements (e.g. the primacy of private doctors' practices), task division in the welfare state (e.g. social workers' history in a welfare state), and the approach towards addiction (e.g. the medical model) make it hard to use addiction as a single frame of observation. Instead, addiction should be understood as an abstract concept which can only be observed in its different shapes, like problem drinking, gambling and eating. Using addiction to describe all kind of excessive and harmful behaviours in general risks reducing addiction to a concept without any explanatory power in itself and risks ignoring the multifarious cultural layers involved in the "interactive kind" (Hacking 1999) of addiction.

Also *culture* runs the risk of being used as a concrete explanatory, as a black box of explanation. This often results in explaining cultural differences by culture itself. Therefore, the concept of culture needs to be developed further into a theory, which takes into account the different hierarchical layers that make up culture. This would offer the opportunity to study the interrelation between the different occurrences of culture and their expressions like practices and institutions, and to compare these between countries or "geographies" (Sulkunen 2013). The complexity of this topic became obvious in this dissertation and the remaining vagueness of some of the results demands further development in cross-cultural comparative methodologies. The method should be able to catch not only differences, but should be capable of relating these differences to the different levels of culture. Taking into account how little we still know about the interrelatedness between the different layers of culture and the interactive character of the subject matter (Hacking 1999), qualitative approaches seem to be necessary to disentangle not only culture but also welfare arrangements (Pfau-Effinger 2005).

As practical advice this dissertation suggests a.) that despite its complexity, addiction as an abstract concept – one that directs our efforts at explaining the contradictory human behaviour of knowing that it would be better to quit (e.g. drinking), but having problems with this task – remains

necessary (Heather 2013). Having shown that addiction is socially constructed does not mean that the problems are not real, or that the concept of addiction would not be useful (Room 2003). These problems are a daily reality for GPs and SWs, who are often lacking specific measures to help but need to react somehow nevertheless. The informants of this study often raised the issue of lacking concrete approaches to handle addiction problems in their different forms. Having no concept of addiction would make it hard to articulate their concerns and to target research towards new treatment approaches in gate keepers' offices, which are obviously necessary.

Based on the culture-level bound character of addiction, this dissertation suggests nevertheless, b.) checking for possible tensions between new treatment approaches (e.g. brief interventions) – proven effective in one setting – and the "target culture", e.g. the institutional context of the "treatment personnel", before trying to implement the new measure. In this way it would be possible to identify beforehand which layer of culture possibly collides with the new treatment approach and to adjust, for example, the institutional context, or refrain from using this kind of treatment in a particular institutional context. It is important in this process, before making hard and fast conclusions, to remember, first, that the institutional context might be wider than that initially associated with the treatment measure (like the organisation of primary health care or a profession's history) and, second, that institutions (like the traditional approach towards addiction) as repertoires of dispositions for action, structure the social world for a longer time than we might expect and as well being more binding than non-institutionalised images.

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